W.T.I.P
WEST TEXAS INJURY PREVENTION

Authorized Services Form:

Patient Name: _____ SS#: _____

*Picture ID required -If you wear glasses please bring them for physical

Date of Services: _____ Appt Time: _____

Signature of Person Authorizing Services: _____

(Please check all services that need to be rendered and send via Fax or with Patient to us)

- ☐ Triage Physical (injury only)
- ☐ Employment Physical
- ☐ DOT Physical with Med Card
- ☐ Back Fitness Assessment
- ☐ Lift/Climb Assessment
- ☐ Hearing Exam (Audiogram)
- ☐ Pulmonary Function Test
- ☐ Fit Testing/Questionnaire
- ☐ Fit Questionnaire Only
- ☐ TB Test
- ☐ Hep B / Tetanus / Flu Vaccine
- ☐ EKG
- ☐ X-Ray:
- ☐ Lab:
- ☐
- ☐ Other: _____

Drug Testing:

☐ **Observed** ☐ **Not Observed**

- ☐ **DOT** Drug Test (**Urine** Lab Based)
- ☐ **Non Dot** Drug Test (**Urine** Lab Based)
- ☐ **Non Dot** Drug Test (***Hair*** Lab Based)
- ☐ **Instant** 10 Panel Drug Test (**Urine** Rapid)

Note If you have a Company CCF on File you do not have to bring one

- ☐ **DOT** Breath Alcohol Testing
- ☐ **NON-DOT** Breath Alcohol Testing

Reason for Testing:

- ☐ Pre-Employment
- ☐ Random
- ☐ Post Accident
- ☐ Promotion
- ☐ Follow up (Observed)
- ☐ Return to Duty
- ☐ Reasonable Suspicion (Obs)
- ☐ Pre Access
- ☐ Other

☐Check Box if Billing Info is Same as Company Info

Company Information	Billing or Third Party Administrator Information
Company Name:	Company Name:
Attn:	Name:
Address:	Address:
City,State,Zip:	City,State,Zip:
Phone:	Phone:
Fax:	Fax:
Email:	Email:

☐FAX Results ☐EMail Results to DER ☐Patient Returns With Result

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