Wilson Immediate Care, PA
1725 S. Tarboro Street SW
Wilson, NC 27893
(252) 237-2891

MEDICAL TREATMENT AUTHORIZATION FORM

Patient Name:_____ Date:_____

Employer Name:_____ Employer Phone:_____

Bill To:_____ Address:_____

_____ _____
Authorizing Individual Authorizing Signature

Please advise your employee picture ID is required at the time of service.

PLEASE INDICATE THE SERVICES YOUR COMPANY IS AUTHORIZING FOR THE PATIENT LISTED ABOVE

Reason for Visit

Employee Injury Care

- ☐ Workers, Comp Injury Visit
- ☐ Workers' Comp Follow Up
- ☐ Date of Injury _____
- ☐ Type of Illness/Injury___
- ☐ Body Part Affected _____
_____

Alcohol Testing

- ☐ Breath Alcohol
- ☐ Blood Alcohol

Drug Screens

- ☐ DOT Drug Screen
- ☐ Non-DOT Drug Screen
- ☐ Pre-Employment
- ☐ Post-Accident
- ☐ Random
- ☐ Reasonable Cause
- ☐ Rapid Drug Screen

Physicals

- ☐ Pre-Employment
- ☐ DOT Physical
  - ☐ Glucose testing if needed
- ☐ NON-DOT Physicals
  - ☐ Glucose testing if needed
- ☐ Reason to Work
- ☐ Other _____
- ☐ Visual Screening
- ☐ Audiogram
- ☐ Pulmonary Function

Please indicate the appropriate test

Health Screenings

- ☐ Hepatitis B Vaccine
- ☐ Hepatitis B Titer
- ☐ TB/PPD
- ☐ Flu Shot
- ☐ Other _____
- ☐ Other _____

**PLEASE FAX ALL RESULTS PERFORMED TO:

Name: _____

Fax: _____

FAX OR EMAIL THE COMPLETED FORM TO

(252)237-7493 OR wicoffice@centurylink.net