Concentra

(Patient Must Present Photo ID at Time of Service)

Authorization for Examination or Treatment

Patient Name: _____ Social Security Number: _____

Employer: Saint Louis University Employee Health Date of Birth: _____

Street Addres: 3547 Olive Street Phone Number: _____

Work Related

☐ Injury Care ☐ Blood Borne Pathogen Exposure

Date of Injury: _____

****Substance Abuse Testing**** Check all that apply

For Post **AUTO** Accident Testing, injury care w/ 12 panel & breath alcohol.

☐ Injury care w/ non-reg. USD 12 pnl. ☐ Breath Alcohol

☐ Rapid eCup + 10 pnl. ☐ Non-reg. USD 16 pnl.

☐ Other: _____

Physical Examination

☐ Preplacement ☐ Baseline ☐ Annual ☐ Exit

DOT Physical Examination

☐ Preplacement ☐ Recertification

Special Examination

☐ Asbestos ☐ Respirator ☐ Audiogram

☐ Medical Surveillance

☐ Hazmat ☐ Human Performance Evaluation

☐ Exposure: _____

☐ Other: _____

Type of Substance Abuse Testing

Please select reason for testing

☐ Pre-Placement ☐ Reasonable Cause

☐ Post Auto Accident ☐ Random

☐ Follow-Up

Billing (check if applicable)

☐ Workers' Compensation

☐ Department to pay

☐ Employee to pay charges

Special Instructions/comments:

Due to the nature of these specific services, only the patient and the medical staff are allowed in the testing/treatment area. Please alert your employee so that they can make arrangements for children or others that might otherwise be accompanying them to the medical center.

Authorized by: _____ Title: _____

Please print

Phone: _____ Date: _____

Updated 5/22/2025