Stormont Vail
WORK CARE

Authorization for Treatment

General Information

Patient Name: _____

Date of Birth: _____

Employer Name: Auburn-Washburn USD 437

Employer Contact Phone #: 785-339-4036 Employer Email: svarccche@usd437.net

Date of Injury: _____ Parts of Body Involved: _____

Worker's Compensation Billing Information: Claim #: _____ Claims Adjuster: _____

Work Comp Carrier: KASB Workers Compensation Fund, Inc.

Phone #/Fax #/Email: 785-271-4533/785-272-7870/lmaisberger@kasb.org

Exams

- ☐ Audiogram
- ☐ DOT Physical
- ☐ DOT Recertification
- ☑ Initial Work Comp Injury
- ☐ PFT
- ☐ Respirator Physical
- ☐ Work Care Physical
- ☐ Work Comp Follow-Up
- ☐ Fit Testing *(circle: quantitative or qualitative)*

Drug & Alcohol Screening

- ☐ DOT Urine Drug Screen
- ☐ DOT Breath Alcohol
- ☐ Non-DOT Breath Alcohol
- ☑ Non-DOT Urine Drug Screen
- ☐ Non-DOT Rapid Urine Drug Screen

Reason for Drug & Alcohol Test

- ☐ Pre-Employment
- ☑ Post-Accident
- ☐ Random
- ☐ Observed
- ☐ Reasonable Suspicion/Cause
- ☐ Other

Immunizations

- ☐ TB Skin Test *(not performed on Thursdays)*
- ☐ Tdap
- ☐ Hepatitis A
- ☐ MMR
- ☐ Hepatitis B
- ☐ Influenza
- ☐ Rabies
- ☐ Varicella

Lab Titers

- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ MMR
- ☐ QuantiFERON Gold
- ☐ Rabies
- ☐ Varicella
- ☐ Tspot

Authorized Signature to Perform Services: _____

Name/Title: Chelsea Svarczkopf / Exec. Dir. of Human Resources **Date:** _____

Clinic Hours: Monday - Friday 8:00 A.M. - 5:00 P.M. *No Drug Screens/BAT after 4:00 P.M.*

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