vybe urgent care

☐ Authorization Form

Information identified with * is required

***Patient Name:** _____ ***Date:** _____

***Company: Case policy #** 634311 – ENTERPRISE AWARDS ***Phone:** ( ) _____

vybe location: _____

Please provide the above patient with the following services: (please check all that apply)	
Drug Screen Testing ☐ 10 panel rapid drug screen ☐ DOT urine drug screen, 5 panel w/ MRO review ☐ Non DOT urine drug screen, 10 panel drugs of abuse ☐ UDS collection only (COC provided) ☐ Rapid saliva alcohol test	**Office Testing** ☐ Audiology ☐ EKG ☐ Pulmonary function test (may need chest X-ray if abnormal) ☐ Respirator fit test ☐ PPD (Tuberculosis Screen) ☐ Quantiferon Gold Test ☑ RAPID – COVID Screen (Quidel Sofia) ☐ PCR Test
Physicals ☐ Pre-Employment /Annual Physical Exam ☐ DOT/non DOT Commercial Drivers License (CDL) ☐ OSHA respirator clearance w/ medical surveillance physical ☐ OSHA respirator medical surveillance questionnaire ☐ School bus driver physical ☐ Firefighter Physical (NFPA 1582) –Company contract	**Radiology** ☐ Chest X-ray ☐ Lumbar Spine **Laboratory Testing** ☐ Comprehensive blood count ☐ Comprehensive metabolic profile ☐ Lipid panel ☐ Urinalysis ☐ Hep B Titer ☐ MMR Titer
Vaccines ☐ Hepatitis A, per dose (immunity = 2 doses) ☐ dose 1 ☐ dose 2 ☐ Hepatitis B, per dose (immunity = 3 doses) ☐ dose 1 ☐ dose 2 ☐ dose 3 ☐ Flu vaccine ☐ Tetanus	
Workers Compensation ☐ Worker's Compensation Injury Treatment: Date of Injury:_____Type of Injury:_____ ☐ Post-accident 10 panel rapid drug screen (Bill as Case Policy)	

Preferred communication for clinical results:

☐ Phone( )_____ ☐ Fax ( )_____ ☐ Email_____

Date