



**North Oaks Urgent Care Clinic – Hammond**  
*Located within North Oaks Rehabilitation Hospital*  
 1900 S. Morrison Blvd., Suite A • Hammond, LA 70403  
 Open Everyday: 7 a.m. - 8 p.m. for injury care  
 Open Monday-Friday 8 a.m.- 5 p.m. for physicals and testing  
 Phone: (985) 230-5726 Fax: (985) 230-5683

**North Oaks Urgent Care Clinic – Walker**  
*Located next to Walmart*  
 28050 Walker S. Rd, Suite L • Walker, LA 70785  
 Open Everyday: 7 a.m. - 8 p.m. for injury care  
 Phone: (225) 664-2111 Fax: (225) 664-2888

**AUTHORIZATION FOR TREATMENT**

EMPLOYEE INFORMATION		
Name (Last, First)		Date / /
SS#	Date of Birth / /	Employee Phone #
EMPLOYER INFORMATION		
Employer's Name	Employer's Phone #	Employer's Fax #
Employer's Address	City	State Zip
Name/Title of Authorizer	Signature of Authorizer	
Employee DER:	DER Phone #:	

**SERVICES REQUESTED**

Please indicate the full range of services requested by placing a check (✓) in the box(es) next to the appropriate service(s). Please ensure ALL services required are checked. Your employee(s) MUST have valid picture identification for positive verification. The Emergency Room can be utilized for after-hours Occupational Health injury care daily from 8 p.m.—7 a.m.; and on holidays.

**Release paperwork VIA:**     Fax     Mail     Email     With Employee     Do NOT Release with Employee

	Pre-Employment	Random	Post-Accident	Annual	Reasonable Suspicion	Other
DOT Physical Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DOT Breath Alcohol Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DOT Urine Drug Screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-DOT Physical Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-DOT Breath Alcohol Test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Non-DOT Urine Drug Screen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Screen Quick Check	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Treatment:(i.e., X-ray) \_\_\_\_\_

TB Skin Test     Hepatitis B Injection     Flu Vaccine     Tetanus     Injury Treatment

- Bill to: \_\_\_\_\_
- File with Workers' Compensation Insurance.
- Self pay (employer to reimburse employee)
- Email results to: \_\_\_\_\_

WORKERS' COMPENSATION INFORMATION		
Workers' Comp. Insurance Carrier	Claim#	Adjuster's Name
Workers' Comp. Insurance Carrier Address	Workers' Comp. Insurance Carrier Phone #	