Henry Ford HEALTH SYSTEM
Occupational Health

PATIENT NAME: _____

ARRIVAL TIME: _____

DATE: _____

AUTHORIZATION FOR TREATMENT & BILLING

☐ Harbor Town Medical Center
3370 East Jefferson
Detroit, MI 48207
Occupational Health Phone: 313-656-1618
Main Clinic Phone: 313-656-1600
Fax: 313-656-1610

☐ Henry Ford Medical Center
23050 West Rd., Suite 130
Brownstown, MI 48193
Phone: 734-671-1444
Fax: 734-671-1475

EMPLOYER Riverview Community School District PHONE 734-285-9662 EMAIL aabraham@riverviewschools.com FAX 734-285-9822

ADDRESS 13425 Colvin Street CITY Riverview STATE MI ZIP 48193

EMPLOYEE _____ PHONE _____
Last name First name

ADDRESS _____ DOB _____

BILLEE NAME & ADDRESS
IF OTHER THAN ABOVE _____

Has been authorized to see you for: (SEE ATTACHED)

- ☐ Vision Screening
- ☐ Hearing Screening
- ☐ Respirator FIT Testing
- ☐ Drug Screen
  - Type 10 panel send-out
- ☐ New Occupational Injury/Illness
- ☐ Evaluation Only / Please contact Medical Department
- ☐ Pre-Placement Physical Examination
- ☐ Annual Surveillance Examination
- ☐ Return to Work Examination
- ☐ Follow-up Occupational Injury/Illness
- ☐ Non-Occupational Emergency
- ☐ Other _____
- ☐ Lift Test
  - simple
  - complex

Name & Authorizing Signature – Position or Title _____ Phone 734-285-9662 Date _____
Personnel Specialist

THIS SECTION FOR HFHS STAFF ONLY

DIAGNOSIS / TREATMENT

_____

_____

RECOMMENDATION

- ☐ May return to regular work with / without restriction
  Date: _____
- ☐ Restrictions:
  _____
  _____
- ☐ Resume regular work on _____(date)
- ☐ As much as Splint/Bandage permits
- ☐ No work: Estimated date of return
  _____(date)
- ☐ Other (explain)
  _____
  _____

RESULTS OF PRE-PLACEMENT EXAM

- ☐ Approved
- ☐ Approved Conditionally, reason: _____
  _____
- ☐ **NOT** Approved, reason: _____
  _____

DISPOSITION:

- ☐ Returned to work _____(date)
- ☐ Sent home _____(date)
- ☐ Discharged to Company Medical Department
- ☐ Return only if problems to _____(dept.)
  Return to _____(clinic) on _____(date)

Signature of Provider _____

Company Contacted (yes/signature) phone / fax _____ **(left message/signature)** _____

Time of discharge _____