☐ 271 N. Fairview Ave. #101
(805) 681-7411

☐ 2954 State Street
(805) 682-7411

☐ 319 N. Milpas
(805) 965-3011

Referral and Authorization for Treatment

This form is to be completed by the company supervisor of ill or injured party.

Patient Name _____ Social Security No. _____

Company _____ Phone _____ B/D _____

Address _____ City _____ Zip _____

Date of Injury/Illness _____ Time _____ Place _____

PLEASE CHECK APPROPRIATE BOX:

☐ WORK-RELATED INJURY ☐ WORK-RELATED ILLNESS ☐ NON WORK-RELATED
☐ ANNUAL PHYSICAL ☐ INSURANCE PHYSICAL ☐ DRUG SCREEN
☐ PRE-EMPLOYMENT PHYSICAL ☐ RETURN TO WORK PHYSICAL
☐ SPECIAL EXAM ☐ OTHER

PLEASE CHECK BOXES RELATING TO EMPLOYEE'S WORK ENVIRONMENT:

1. Routinely Lifts: ☐ Under 25 lbs. ☐ 25 lbs. ☐ 50 lbs. ☐ 75 lbs ☐ 100 lbs.
2. Environment: ☐ Wet ☐ Dry
3. ☐ Stands for _____ hours per day. ☐ Sits for _____ hours per day.
4. Company has light duty: ☐ YES ☐ NO If yes, describe: _____
5. Other work environment factors: _____

☐ **BILL BUSINESS DIRECTLY**

☐ **BILL W/C INSURANCE CARRIER**

Insurance Co. _____

Address _____

City/State/Zip _____

Supervisor _____ Date _____