



**SACRAMENTO
OCCUPATIONAL
MEDICAL GROUP**

Power Inn Clinic
5665 Power Inn Rd. #120
Sacramento, CA 95824
P: (916) 387-6929
F: (916) 387-6977

Rancho Cordova Clinic
2708 Mercantile Dr.
Rancho Cordova, CA 95742
P: (916) 469-9037
F: (916) 469-9814

Patient _____

Department _____ Position _____

Phone _____ Date _____

If Temp, what Agency? _____

SERVICES REQUESTED

- | | |
|--|---|
| <input type="checkbox"/> Work-Related Injury Treatment | <input type="checkbox"/> Urine Drug Screen, Non-DOT |
| <input type="checkbox"/> Pre-Placement Physical Exam | <input type="checkbox"/> DOT Drug Screen |
| <input type="checkbox"/> DOT Physical Exam | <input type="checkbox"/> Breath Alcohol Test |

For Drug Screen or Alcohol Test, please check the following type:

- | | |
|---|--|
| <input type="checkbox"/> Pre-Placement | <input type="checkbox"/> Post-Accident |
| <input type="checkbox"/> Random | <input type="checkbox"/> Return-To-Duty |
| <input type="checkbox"/> Reasonable Suspicion | <input type="checkbox"/> Other Screen: _____ |
| <input type="checkbox"/> Other _____ | |

AUTHORIZATION FOR MEDICAL SERVICES

PLEASE BE PROMPT AND BRING THIS
AUTHORIZATION WITH YOU.

RESPONSIBLE PARTY

- Employer Insurance T.P.A. Patient

Insurance Company
or T.P.A. Name: _____

Policy or Account # _____

Phone _____ DOI _____

Claim No. _____

Employer _____

Address _____

Phone _____ Contact _____

We are authorizing Sacramento Occupational Medical Group to provide treatment to our employee listed on this form. By doing so, we acknowledge that if the claim is denied by our insurance carrier, we will notify SOMG of the denial and will be responsible for all services rendered and any medically-necessary items dispensed.

Authorized By _____

