

TOXICOLOGY PANEL REQUISITION

REASON FOR TESTING

- Pre-employment
- Random
- Reasonable Suspicion
- Post-accident
- Return to Duty
- Follow-up
- Other (Specify): _____

ACCOUNT INFORMATION

Client:	Site:	Ordering Provider:	
Site Contact:	Email:	Phone Number:	NPI:

PATIENT DEMOGRAPHICS

Collection Date: / /	Collection Time: <input type="checkbox"/> AM <input type="checkbox"/> PM	Collection: <input type="checkbox"/> Split <input type="checkbox"/> Single <input type="checkbox"/> None Provided	Temperature checked within 4 minutes of collection and is between 90-100° F or 32-38° C: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Observed	Collector (Initials):
Last Name:	First Name:	Phone Number:		
Street Address:	City:	State:	Zip Code:	State County:
Date of Birth: / /	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Undefined		
Race: <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Mixed Race <input type="checkbox"/> American Indian/Native Alaskan <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Hawaiian/Pacific Island <input type="checkbox"/> Asian <input type="checkbox"/> Other/Unknown				

CPT CODES

80307	G0480	G0481	G0482	G0483
Urine Screening	1-7 drug class (es)	8-14 drug class (es)	15-21 drug class (es)	22 or more drug class (es)

DIAGNOSIS CODES

REQUIRED

1. _____	2. _____
3. _____	4. _____

Enter POC Results OR Select Drug Screening Test To Be Performed

Drug Class	Select Drug	Positive (+)	Negative (-)	Drug Class	Select Drug	Positive (+)	Negative (-)	Drug Class	Select Drug	Positive (+)	Negative (-)
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Opiates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MDMA (Ecstasy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oxycodone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benzodiazepines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Methadone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phencyclidine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buprenorphine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	THC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PANEL TYPE: URINE ORAL FLUID **PANEL OPTIONS:** Complete Panel Custom Panel On File Attached

Urine Panel	Qualitative	Quantitative	Reflex	Oral Fluid	Urine Panel	Qualitative	Quantitative	Reflex	Oral Fluid
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	OTC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-
Ethyl glucuronide/Ethyl sulfate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	Dextromethorphan/Dextroprphan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Methadone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Methadone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	EDDP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anticonvulsants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	Opiates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-
Gabapentin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	Codeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregabalin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Morphine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	Hydrocodone/Norhydrocodone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Butalbital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	Hydromorphone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phenobarbital	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	Fentanyl analogues/Norfentanyl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benzodiazepines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Opioids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-
Alprazolam/a-Hydroxyalprazolam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meperidine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diazepam/Nordiazepam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Normeperidine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-
Oxazepam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sufentanil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-
Temazepam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tapentadol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a-Hydroxytriazolam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	Tramadol/O-Desmethyltramadol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7-aminoclonazepam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	Oxycodone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Desalkylflurazepam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	Oxycodone/Noroxycodone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lorazepam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	Oxymorphone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buprenorphine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Synthetic Cannabinoids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-
Buprenorphine/Norbuprenorphine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	UR-144 Hydroxypentyl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-
Naloxone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Synthetic Stimulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MDPV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-
Benzoylcegonine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mephedrone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Methylone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-
6-MAM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	THC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Illicit Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	THC-COOH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acetyl fentanyl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	THC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carfentanil	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-	Miscellaneous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ketamine/Norketamine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cotinine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MDA, MDEA, MDMA (Ecstasy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Naltrexone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Relaxants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Carisoprodol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

PRESCRIBED MEDICATION

- AMPHETAMINES**
 - Amphetamine (Adderall)
 - Methamphetamine(Desoxyn)
- ANTICONVULSANTS**
 - Gabapentin (Neurontin)
 - Pregabalin (Lyrica)
- BARBITURATES**
 - Butalbital (Bupap)
 - Pentobarbital (Nembutal)
 - Phenobarbital (Donnatal)
 - Secobarbital (Seconal)
- HYPNOTICS/SEDATIVES**
 - Zaleplon (Sonata)
 - Zolpidem (Ambien)
- BENZODIAZEPINES**
 - Alprazolam (Xanax)
 - Clonazepam (Klonopin)
 - Lorazepam (Ativan)
 - Midazolam (Versed)
 - Diazepam (Valium)
 - Oxazepam (Serax)
 - Temazepam (Restoril)
- MUSCLE RELAXANTS**
 - Carisoprodol (Soma)
 - Meprobamate (Equanil)
- OTC/COUGH SUPPRESSANTS**
 - Dextromethorphan (Robitussin OM)
- OPIATES**
 - Codeine (Tylenol ff/)
 - Fentanyl (Duragesic)
 - Hydrocodone (Vicodin)
 - Hydromorphone (Dilaudid)
 - Morphine (MS Conlin)
 - Naloxone (Suboxone)
 - Oxycodone (OxyContin)
 - Oxymorphone (Opana)
- OPIOIDS**
 - Buprenorphine (Suboxone)
 - Meperidine (Demerol)
 - Methadone (Dofopine)
 - Propoxyphene (Darvon)
 - Tapentadol (Nucynta)
 - Tramadol (Ultram)
- SSRI/SNRI/**
- NDRI ANTIDEPRESSANTS**
 - Citalopram (Celexa)
 - Fluoxetine (Prozac)
 - Sertraline (Zoloft)
 - Venlafaxine (Effexor)
- TRICYCLIC**
- ANTIDEPRESSANTS**
 - Amitriptyline (Elavil)
 - Desipramine (Norpramin)
 - Doxepin (Silenor)
 - Imipramine (Tofranil)
 - Ketamine (Kelalor)
 - Nortriptyline (Pamemor)
- OTHER ANTIDEPRESSANTS**
 - Bupropion (Wellbutrin)
 - Trazodone (Desyrel)
- ADDITIONAL MEDICATIONS**

BILLING INFORMATION

Insurance Company:	Group Number:	Policy Number:	<input type="checkbox"/> Self-Pay
Name of Insured:	Relationship to Insured:	DOB of Insured: / /	

AUTHORIZING SIGNATURES

Patient Request: I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediates, Blue Shield, or other carriers any information needed for this or related claims. I permit a copy of this authorization to be used in place of the original; and request payment of medical insurance benefits.

Print Patient Name:	Print Signature:	Date:
----------------------------	-------------------------	--------------

Physician Certification: I acknowledge that documentation to support medical necessity for all tests ordered is recorded in the patient's chart. If not signed, Authorized Healthcare Provider affirms that test orders are placed in patient file with provider signature and will be available upon request. The Office of the Inspector General requires documentation in patient medical chart including date of service, tests ordered and documentation to support medical necessity.

Provider Authorizing Name:	Provider Authorizing Signature:	Date:
-----------------------------------	--	--------------