



# ORAL FLUID TOXICOLOGY REQUISITION FORM

## SPECIMEN COLLECTION INFORMATION

DATE TIME

COLLECTOR



FOR LAB USE ONLY

## PATIENT INFORMATION

## BILLING INFORMATION

FIRST NAME  
LAST NAME  
MIDDLE INITIAL ☐ MALE ☐ FEMALE  
DOB SSN  
ADDRESS  
CITY STATE  
ZIPCODE PHONE

☐ MEDICARE ☐ MEDICAID ☐ PATIENT ☐ COMMERCIAL  
RELATIONSHIP ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER  
INSURANCE NAME  
ID #  
GROUP #  
WORKERS COMP INFO  
DATE OF INJURY

## PRESCRIBED MEDICATIONS

<input type="checkbox"/> ACTIQ® <input type="checkbox"/> ADDERALL® <input type="checkbox"/> ALPRAZOLAM <input type="checkbox"/> AMBIEN® <input type="checkbox"/> AMITRIPTYLINE <input type="checkbox"/> ARIPIPRAZOLE <input type="checkbox"/> ATIVAN® <input type="checkbox"/> BUPRENORPHINE <input type="checkbox"/> BUSPAR® <input type="checkbox"/> BUTALBITAL <input type="checkbox"/> BUTRANS® <input type="checkbox"/> CARBAMAZEPINE	<input type="checkbox"/> CARISOPRODOL <input type="checkbox"/> CELEXA® <input type="checkbox"/> CITALOPRAM <input type="checkbox"/> CLONAZEPAM <input type="checkbox"/> CLOZAPINE <input type="checkbox"/> CODEINE <input type="checkbox"/> CYCLOBENZAPRINE <input type="checkbox"/> CYMBALTA® <input type="checkbox"/> DARVOCELT-N® <input type="checkbox"/> DELSYM® <input type="checkbox"/> DEMEROL® <input type="checkbox"/> DEXTROPHAN	<input type="checkbox"/> DILANTIN® <input type="checkbox"/> DILAUDID® <input type="checkbox"/> DOLOPHINE® <input type="checkbox"/> DOXEPIN <input type="checkbox"/> DULOXETINE <input type="checkbox"/> DURAGESIC® <input type="checkbox"/> DURAMORPH® <input type="checkbox"/> EFFEXOR® <input type="checkbox"/> ELAVIL® <input type="checkbox"/> FENTANYL <input type="checkbox"/> FLEXERIL® <input type="checkbox"/> FLUNITRAZEPAM <input type="checkbox"/> FLUOXETINE	<input type="checkbox"/> FLURAZEPAM <input type="checkbox"/> GABAPENTIN <input type="checkbox"/> GEODON® <input type="checkbox"/> HALOPERIDOL <input type="checkbox"/> HYDROCODONE <input type="checkbox"/> IMIPRAMINE <input type="checkbox"/> IONSYS® <input type="checkbox"/> KADIAN® <input type="checkbox"/> LORAZEPAM <input type="checkbox"/> LORCET-HD® <input type="checkbox"/> LYRICA® <input type="checkbox"/> MAPROTILINE <input type="checkbox"/> MEPERIDINE	<input type="checkbox"/> METHADONE <input type="checkbox"/> METHAMPHETAMINE <input type="checkbox"/> METHYLPHENIDATE <input type="checkbox"/> MIDAZOLAM <input type="checkbox"/> MIRTAZAPINE <input type="checkbox"/> MORPHINE <input type="checkbox"/> MS CONTIN® <input type="checkbox"/> NALOXONE <input type="checkbox"/> NALTREXONE <input type="checkbox"/> NUCYNTA® <input type="checkbox"/> NYQUIL® <input type="checkbox"/> OLANZAPINE <input type="checkbox"/> OXAZEPAM	<input type="checkbox"/> OXYCODONE <input type="checkbox"/> OXYCONTIN® <input type="checkbox"/> PAROXETINE <input type="checkbox"/> PHENOBARBITAL <input type="checkbox"/> PHENYTOIN <input type="checkbox"/> PREGABALIN <input type="checkbox"/> PRISTIQ® <input type="checkbox"/> PROPOXYPHENE <input type="checkbox"/> PROZAC® <input type="checkbox"/> QUETIAPINE <input type="checkbox"/> RESTORIL® <input type="checkbox"/> ROBITUSSIN® <input type="checkbox"/> ROXICODONE®	<input type="checkbox"/> SEROQUEL® <input type="checkbox"/> SERTRALINE <input type="checkbox"/> SONATA® <input type="checkbox"/> SUBOXONE® <input type="checkbox"/> TAPENTADOL <input type="checkbox"/> TEGRETOL® <input type="checkbox"/> TEMAZEPAM <input type="checkbox"/> TRAMADOL <input type="checkbox"/> ULTRAM® <input type="checkbox"/> VENLAFAXINE <input type="checkbox"/> VICODIN® <input type="checkbox"/> VICOPROFEN® <input type="checkbox"/> VIVITROL®	<input type="checkbox"/> VYVANSE® <input type="checkbox"/> XANAX® <input type="checkbox"/> ZALEPLON <input type="checkbox"/> ZIPRASIDONE <input type="checkbox"/> ZOLOFT® <input type="checkbox"/> ZOLPIDEM <input type="checkbox"/> ZYPREXA® <input type="checkbox"/> OTHER <input type="checkbox"/> OTHER <input type="checkbox"/> OTHER <input type="checkbox"/> OTHER <input type="checkbox"/> DRUG LIST ATTACHED <input type="checkbox"/> NO DRUG PRESCRIBED
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## ICD-10 CODES

1  
2  
3  
4  
5  
6

## ORAL FLUID DRUG CONFIRMATION (DEFINITIVE OR QUANTITATIVE TESTING UTILIZING LC-MS/MS TECHNOLOGY)

<input type="checkbox"/> <b>AMPHETAMINES</b> <b>01</b> <input type="checkbox"/> AMPHETAMINE <input type="checkbox"/> METHAMPHETAMINE	<input type="checkbox"/> <b>BUPRENORPHINE</b> <b>06</b> <input type="checkbox"/> BUPRENORPHINE <input type="checkbox"/> NORBUPRENORPHINE	<input type="checkbox"/> <b>KRATOM (ALKALOIDS)</b> <b>013</b> <input type="checkbox"/> 7-HYDROXYMITRAGYNE <input type="checkbox"/> MITRAGYNE	<input type="checkbox"/> <b>OPIOIDS &amp; OPIATE ANALOGS</b> <b>019</b> <input type="checkbox"/> 6-BETA-NALTREXOL <input type="checkbox"/> MEPERIDINE <input type="checkbox"/> NALOXONE <input type="checkbox"/> NALTREXONE <input type="checkbox"/> NORMEPERIDINE	<input type="checkbox"/> <b>TAPENTADOL</b> <b>025</b> <input type="checkbox"/> TAPENTADOL
<input type="checkbox"/> <b>ANTIDEPRESSANTS, SEROTONERGIC CLASS</b> <b>02</b> <input type="checkbox"/> FLUOXETINE <input type="checkbox"/> PAROXETINE <input type="checkbox"/> SERTRALINE	<input type="checkbox"/> <b>CANNABINOIDS</b> <b>07</b> <input type="checkbox"/> THC	<input type="checkbox"/> <b>MDMA (ECSTASY)</b> <b>014</b> <input type="checkbox"/> MDA <input type="checkbox"/> MDMA	<input type="checkbox"/> <b>OXYCODONE</b> <b>020</b> <input type="checkbox"/> NOROXYCODONE <input type="checkbox"/> OXYCODONE <input type="checkbox"/> OXYMORPHONE	<input type="checkbox"/> <b>TRAMADOL</b> <b>026</b> <input type="checkbox"/> O-DESMETHYLTRAMADOL <input type="checkbox"/> TRAMADOL
<input type="checkbox"/> <b>ANTIDEPRESSANTS, OTHERS</b> <b>03</b> <input type="checkbox"/> TRAZODONE <input type="checkbox"/> VENLAFAXINE	<input type="checkbox"/> <b>COCAINE</b> <b>08</b> <input type="checkbox"/> BENZOYLECGONINE <input type="checkbox"/> COCAINE	<input type="checkbox"/> <b>METHADONE</b> <b>015</b> <input type="checkbox"/> EDDP <input type="checkbox"/> METHADONE	<input type="checkbox"/> <b>PCP (PHENCYCLIDINE)</b> <b>021</b> <input type="checkbox"/> PHENCYCLIDINE	<b>→ PLEASE ORDER ONLY THE MEDICALLY NECESSARY DRUG TESTING FOR THE DIAGNOSIS OR TREATMENT OF THE PATIENT BY MARKING A CHECKBOX AT A DRUG CLASS LEVEL, TESTING FOR ALL THE ANALYTES WITHIN THE DRUG CLASS WILL BE PERFORMED AUTOMATICALLY</b> <input type="checkbox"/> <b>PERFORM COMPREHENSIVE CONFIRMATION TESTING FOR ALL THE DRUG CLASSES AND ANALYTES FROM 01 TO 026.</b>
<input type="checkbox"/> <b>BARBITURATES</b> <b>04</b> <input type="checkbox"/> BUTALBITAL <input type="checkbox"/> PHENOBARBITAL	<input type="checkbox"/> <b>FENTANYLS</b> <b>09</b> <input type="checkbox"/> FENTANYL <input type="checkbox"/> NORFENTANYL	<input type="checkbox"/> <b>METHYLPHENIDATE</b> <b>016</b> <input type="checkbox"/> METHYLPHENIDATE <input type="checkbox"/> RITALINIC ACID	<input type="checkbox"/> <b>PREGABALIN</b> <b>022</b> <input type="checkbox"/> PREGABALIN	
<input type="checkbox"/> <b>BENZODIAZEPINES</b> <b>05</b> <input type="checkbox"/> 7-AMINOCLONAZEPAM <input type="checkbox"/> ALPHA-HYDROXYALPRAZOLAM <input type="checkbox"/> ALPRAZOLAM <input type="checkbox"/> CLONAZEPAM <input type="checkbox"/> LORAZEPAM <input type="checkbox"/> NORDIAZEPAM <input type="checkbox"/> OXAZEPAM <input type="checkbox"/> TEMAZEPAM	<input type="checkbox"/> <b>GABAPENTIN</b> <b>010</b> <input type="checkbox"/> GABAPENTIN	<input type="checkbox"/> <b>MUSCLE RELAXANTS</b> <b>017</b> <input type="checkbox"/> CARISOPRODOL <input type="checkbox"/> CYCLOBENZAPRINE	<input type="checkbox"/> <b>PROPOXYPHENE</b> <b>023</b> <input type="checkbox"/> PROPOXYPHENE	
	<input type="checkbox"/> <b>HEROIN METABOLITE</b> <b>011</b> <input type="checkbox"/> 6-MONOACETYLMORPHINE	<input type="checkbox"/> <b>OPIATES</b> <b>018</b> <input type="checkbox"/> CODEINE <input type="checkbox"/> HYDROCODONE <input type="checkbox"/> HYDROMORPHONE <input type="checkbox"/> MORPHINE <input type="checkbox"/> NORHYDROCODONE	<input type="checkbox"/> <b>SEDATIVE HYPNOTICS</b> <b>024</b> <input type="checkbox"/> cZOLPIDEM	
	<input type="checkbox"/> <b>KETAMINE &amp; NORKETAMINE</b> <b>012</b> <input type="checkbox"/> KETAMINE <input type="checkbox"/> NORKETAMINE			

## HEALTHCARE PROVIDER INFORMATION & AUTHORIZATION

## PATIENT AUTHORIZATION

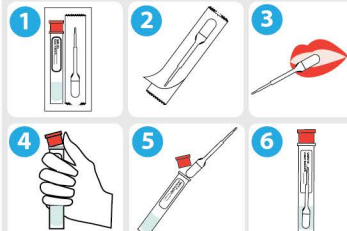
I AUTHORIZE THE ABOVE ORDERED TESTS AS MEDICALLY NECESSARY FOR THIS PARTICULAR PATIENT GIVEN THE PATIENT'S CLINICAL CONDITION

PHYSICIAN SIGNATURE DATE

I CERTIFY THAT I HAVE VOLUNTARILY PROVIDED A FRESH AND UNADULTERATED SPECIMEN FOR ANALYTICAL TESTING. THE INFORMATION PROVIDED ON THIS FORM AND, ON THE LABEL, OFFERED TO THE SPECIMEN TUBE IS ACCURATE. I AUTHORIZE MED SCREEN LABORATORIES (MSL) TO RELEASE THE RESULTS TO THE TREATING AUTHORIZED HEALTHCARE PROVIDER OR FACILITY. I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO MSL FOR SERVICES I RECEIVED. I ACKNOWLEDGE THAT MSL MAY BE AN OUT-OF-NETWORK PROVIDER WITH MY INSURER. I ALSO UNDERSTAND THAT IN SOME CIRCUMSTANCES MY INSURER WILL SEND THE PAYMENT DIRECTLY TO ME. I AGREE TO ENDORSE INSURANCE CHECK AND FORWARD IT TO MSL WITHIN 30 DAYS OF RECEIPT. FAILURE TO DO SO MAY RESULT IN MY ACCOUNT BEING FORWARDED TO COLLECTIONS AND REPORTED TO A CREDIT BUREAU

PATIENT SIGNATURE DATE

## INSTRUCTIONS



PATIENT'S NAME  
DOB



COLLECTOR NAME  
COLLECTION TIME

→ SECURELY PLACE THE SEAL OVER THE TUBE

→ TO BE INSECTED BY MEDSCREEN LABS PERSONELL