


# URINE TOXICOLOGY REQUISITION FORM

## SPECIMEN COLLECTION INFORMATION

DATE	TIME
COLLECTOR	
→ TEMPERATURE IS READ WITHIN 4 MINUTES & NOTED BELOW AS	
<input type="checkbox"/> IN RANGE BETWEEN 90-100 °F	<input type="checkbox"/> OUT OF RANGE
 1234	

## PATIENT INFORMATION

FIRST NAME	
LAST NAME	
MIDDLE INITIAL	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
DOB	SSN
ADDRESS	
CITY	STATE
ZIPCODE	PHONE

## BILLING INFORMATION

<input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> PATIENT <input type="checkbox"/> COMMERCIAL
RELATIONSHIP <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER
INSURANCE NAME
ID #
GROUP #
WORKERS COMP INFO
DATE OF INJURY

## PRESCRIBED MEDICATIONS

<input type="checkbox"/> ABILIFY® <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"/> CLOMIPRAMINE <input type="checkbox"/> CLONAZEPAM <input type="checkbox"/> CLOZAPINE <input type="checkbox"/> CODEINE <input type="checkbox"/> CYCLOBENZAPRINE <input type="checkbox"/> CYMBALTA® <input type="checkbox"/> DARVOCET-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"/> KADIAN® <input type="checkbox"/> LONSY® <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"/> ROBUTUSSIN® <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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## DX CODES ICD-10

1
2
3
4
5
6

## DRUG SCREENING(PRESUMPTIVE OR QUALITATIVE TESTING UTILIZING CHEMISTRY ANALYZERS)

<b>5 PANEL</b> <b>SSR</b> <input type="checkbox"/> AMPHETAMINE <input type="checkbox"/> BENZODIAZEPINES <input type="checkbox"/> COCAINE <input type="checkbox"/> OPIATES <input type="checkbox"/> THC (CANNABINOIDS) <input type="checkbox"/> SPECIMEN VALIDITY	<b>10 PANEL</b> <b>S10R</b> <input type="checkbox"/> AMPHETAMINE <input type="checkbox"/> BARBITURATES <input type="checkbox"/> BENZODIAZEPINES <input type="checkbox"/> COCAINE <input type="checkbox"/> METHADONE <input type="checkbox"/> OPIATES <input type="checkbox"/> OXYCODONE <input type="checkbox"/> PHENCYCLIDINE <input type="checkbox"/> PROPOXYPHENE <input type="checkbox"/> THC (CANNABINOIDS) <input type="checkbox"/> SPECIMEN VALIDITY	<b>12 PANEL</b> <b>S12R</b> <input type="checkbox"/> AMPHETAMINE <input type="checkbox"/> BARBITURATES <input type="checkbox"/> BENZODIAZEPINES <input type="checkbox"/> BUPRENORPHINE <input type="checkbox"/> COCAINE <input type="checkbox"/> ETHANOL <input type="checkbox"/> MDMA <input type="checkbox"/> METHADONE <input type="checkbox"/> OPIATES <input type="checkbox"/> OXYCODONE <input type="checkbox"/> PHENCYCLIDINE	<b>SELECT ONE OR MORE INDIVIDUALLY</b> <input type="checkbox"/> 6-AM (HEROIN) <input type="checkbox"/> AMPHETAMINE <input type="checkbox"/> BARBITURATES <input type="checkbox"/> BENZODIAZEPINES <input type="checkbox"/> BUPRENORPHINE <input type="checkbox"/> COCAINE <input type="checkbox"/> ETHANOL <input type="checkbox"/> FENTANYL <input type="checkbox"/> LSD <input type="checkbox"/> MDMA <input type="checkbox"/> TRICYCLIC ANTIDEPRESSANTS (TCAs) <input type="checkbox"/> METHADONE <input type="checkbox"/> METHAQUALONE <input type="checkbox"/> OPIATES <input type="checkbox"/> OXYCODONE <input type="checkbox"/> PHENCYCLIDINE <input type="checkbox"/> PROPOXYPHENE <input type="checkbox"/> THC (CANNABINOIDS) <input type="checkbox"/> SPECIMEN VALIDITY	<b>FOR ALL SCREENING PANELS, A REFLEX CONFIRMATORY LC-MS/MS TESTING WILL AUTOMATICALLY BE PERFORMED, REPORTED &amp; BILLED IF THERE ARE POSITIVE RESULTS FROM THE INITIALLY ORDERED SCREENING</b> <b>→ IF REFLEX CONFIRMATORY LC-MS/MS TESTING IS NOT REQUIRED FOR ANY SCREENING RESULTS, PLEASE SPECIFY IT BY CHECKING THE BOX BELOW</b> <input type="checkbox"/> <b>REFLEX CONFIRMATORY LC-MS/MS TESTING IS NOT REQUIRED FOR ANY POSITIVE SCREENING RESULTS</b>
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## DRUG CONFIRMATION( DEFINITIVE OR QUANTITATIVE TESTING UTILIZING LC-MS/MS TECHNOLOGY)

<b>ALCOHOL BIOMARKERS</b> <b>C1</b> <input type="checkbox"/> ETHYL GLUCURONIDE (ETG) <input type="checkbox"/> ETHYL SULFATE (ETS)	<b>ANXIOLYTIC</b> <b>C7</b> <input type="checkbox"/> BUSPIRONE	<input type="checkbox"/> ALPHA-HYDROXYALPRAZOLAM <input type="checkbox"/> ALPHA-HYDROXYMIDAZOLAM <input type="checkbox"/> ALPRAZOLAM <input type="checkbox"/> LORAZEPAM <input type="checkbox"/> NORDIAZEPAM <input type="checkbox"/> OXAZEPAM <input type="checkbox"/> TEMAZEPAM	<b>K2/K3/SPICE (CANNABINOIDS,SYNTHETIC)</b> <b>C19</b> <input type="checkbox"/> AB-FUBINACA <input type="checkbox"/> AB-PINACA 5-HYDROXYPENTYL <input type="checkbox"/> AM2201 4-HYDROXYPENTYL <input type="checkbox"/> APINACA 5-HYDROXYPENTYL <input type="checkbox"/> JWH-122 4-HYDROXYPENTYL <input type="checkbox"/> JWH-250 4-HYDROXYPENTYL <input type="checkbox"/> JWH-210 4-HYDROXYPENTYL <input type="checkbox"/> JWH-073 3-HYDROXYBUTYL <input type="checkbox"/> JWH-018 4-HYDROXYPENTYL <input type="checkbox"/> MAM2201 4-HYDROXYPENTYL <input type="checkbox"/> PB-22 5-PENTANOIC ACID <input type="checkbox"/> UR-144 5-HYDROXYPENTYL <input type="checkbox"/> XLR-11 4-HYDROXYPENTYL	<b>OPIATES</b> <b>C25</b> <input type="checkbox"/> CODEINE <input type="checkbox"/> HYDROCODONE <input type="checkbox"/> HYDROMORPHONE <input type="checkbox"/> MORPHINE <input type="checkbox"/> NORHYDROCODONE <input type="checkbox"/> OPIOIDS & OPIATE ANALOGS <b>C26</b> <input type="checkbox"/> 6-BETA-NALTREXOL (NALTREXONE) <input type="checkbox"/> AH-7921 <input type="checkbox"/> DEXTROPHAN <input type="checkbox"/> MEPERIDINE <input type="checkbox"/> NALOXONE <input type="checkbox"/> NORMEPERIDINE	<b>TRAMADOL</b> <b>C33</b> <input type="checkbox"/> O-DESMETHYLTRAMADOL <input type="checkbox"/> TRAMADOL <b>SELECT ONE OR MORE INDIVIDUALLY</b> <input type="checkbox"/> LSD
<b>AMPHETAMINES</b> <b>C2</b> <input type="checkbox"/> AMPHETAMINE <input type="checkbox"/> METHAMPHETAMINE	<b>ANTIPSYCHOTICS</b> <b>C8</b> <input type="checkbox"/> 7-HYDROXYQUETIAPINE <input type="checkbox"/> 9-HYDROXYRISPERIDONE <input type="checkbox"/> DEHYDROARIPIPIRAZOLE <input type="checkbox"/> HALOPERIDOL <input type="checkbox"/> N-DESMETHYLCLOZAPINE <input type="checkbox"/> N-DESMETHYLOLANZAPINE <input type="checkbox"/> ZIPRASIDONE	<b>BUPRENORPHINE</b> <b>C12</b> <input type="checkbox"/> BUPRENORPHINE <input type="checkbox"/> NORBUPRENORPHINE	<b>CRATOM (ALKALOIDS)</b> <b>C20</b> <input type="checkbox"/> 7-HYDROXYMITRAGYLINE <input type="checkbox"/> MITRAGYLINE	<b>OXYCODONE</b> <b>C27</b> <input type="checkbox"/> OXYCODONE <input type="checkbox"/> NOROXYCODONE <input type="checkbox"/> OXYMORPHONE	<b>PLEASE ORDER ONLY THE MEDICALLY NECESSARY DRUG TESTING FOR THE DIAGNOSIS OR TREATMENT OF THE PATIENT</b> <b>→ 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 DRUG CONFIRMATION TESTING FOR ALL THE DRUG CLASSES &amp; ANALYTES LISTED ABOVE FROM C2 TO C33 (WITHOUT ALCOHOL)</b> <input type="checkbox"/> <b>PERFORM COMPREHENSIVE DRUG CONFIRMATION TESTING FOR ALL THE DRUG CLASSES &amp; ANALYTES LISTED ABOVE FROM C1 TO C33 (WITH ALCOHOL)</b>
<b>ANTIDEPRESSANTS, SEROTONERGIC CLASS</b> <b>C3</b> <input type="checkbox"/> DULOXETINE <input type="checkbox"/> FLUOXETINE <input type="checkbox"/> N-DESMETHYLCITALOPRAM <input type="checkbox"/> PAROXETINE <input type="checkbox"/> SERTRALINE	<b>BARBITURATES</b> <b>C9</b> <input type="checkbox"/> BUTALBITAL <input type="checkbox"/> PHENOBARBITAL	<b>CANNABINOIDS, NATURAL</b> <b>C13</b> <input type="checkbox"/> THC-COOH	<b>MDMA (ECSTASY)</b> <b>C21</b> <input type="checkbox"/> MDA <input type="checkbox"/> MDMA <input type="checkbox"/> MDEA	<b>PCP (PHENCYCLIDINE)</b> <b>C28</b> <input type="checkbox"/> PHENCYCLIDINE (PCP)	
<b>ANTIDEPRESSANTS, TRICYCLIC &amp; OTHER CYCLICALS</b> <b>C4</b> <input type="checkbox"/> AMITRIPTYLINE <input type="checkbox"/> DESIPRAMINE <input type="checkbox"/> IMIPRAMINE <input type="checkbox"/> MAPROTILINE <input type="checkbox"/> N-DESMETHYLCLOMIPRAMINE <input type="checkbox"/> N-DESMETHYLDXOEPIN <input type="checkbox"/> N-DESMETHYLMIRTAZAPINE <input type="checkbox"/> NORTRIPTYLINE	<b>BATH SALTS (STIMULANTS,SYNTHETIC)</b> <b>C10</b> <input type="checkbox"/> 5-DBFPV <input type="checkbox"/> ALPHA-PBP <input type="checkbox"/> ALPHA-PPP <input type="checkbox"/> ALPHA-PVP <input type="checkbox"/> BUTYLONE <input type="checkbox"/> DIBUTYLONE <input type="checkbox"/> ETHYLONE <input type="checkbox"/> ETHYLPENTYLONE <input type="checkbox"/> MDPV <input type="checkbox"/> MEPHEDRONE <input type="checkbox"/> METHEDRONE <input type="checkbox"/> METHYLONE <input type="checkbox"/> NAPHYRONE <input type="checkbox"/> PENTYLONE	<b>COCAINE METABOLITE</b> <b>C14</b> <input type="checkbox"/> BENZOYLECGONINE	<b>METHADONE</b> <b>C22</b> <input type="checkbox"/> EDDP <input type="checkbox"/> METHADONE	<b>PREGABALIN</b> <b>C29</b> <input type="checkbox"/> PREGABALIN	
<b>ANTIDEPRESSANTS, OTHERS</b> <b>C5</b> <input type="checkbox"/> HYDROXYBUPROPION <input type="checkbox"/> O-DESMETHYLVENLAFAXINE <input type="checkbox"/> TRAZODONE <input type="checkbox"/> VENLAFAXINE <input type="checkbox"/> VILAZODONE	<b>BENZODIAZEPINES</b> <b>C11</b> <input type="checkbox"/> 2-HYDROXYETHYLFLURAZEPAM <input type="checkbox"/> 7-AMINOCLONAZEPAM <input type="checkbox"/> 7-AMINOFLUNITRAZEPAM	<b>COCAINE METABOLITE</b> <b>C17</b> <input type="checkbox"/> 6-MONOACETYLMORPHINE	<b>METHYLPHENIDATE</b> <b>C23</b> <input type="checkbox"/> RITALINIC ACID	<b>PROPOXYPHENE</b> <b>C30</b> <input type="checkbox"/> PROPOXYPHENE	
<b>ANTIPILEPTICS</b> <b>C6</b> <input type="checkbox"/> CARBAMAZEPINE METABOLITE		<b>HEROIN METABOLITE</b> <b>C18</b> <input type="checkbox"/> KETAMINE <input type="checkbox"/> NORKETAMINE	<b>MUSCLE RELAXANTS</b> <b>C24</b> <input type="checkbox"/> CYCLOBENZAPRINE <input type="checkbox"/> MEPROBAMATE	<b>SEDATIVE HYPNOTICS</b> <b>C31</b> <input type="checkbox"/> cZOLPIDEM <input type="checkbox"/> ZALEPLON	

## HEALTHCARE PROVIDER INFORMATION & AUTHORIZATION

I CERTIFY THAT I HAVE VOLUNTARILY PROVIDED A FRESH AND UNADULTERATED URINE SPECIMEN FOR ANALYTICAL TESTING. THE INFORMATION PROVIDED ON THIS FORM AND, ON THE LABEL, OFFERED TO THE SPECIMEN CUP 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	
I AUTHORIZE THE ABOVE ORDERED TESTS AS MEDICALLY NECESSARY FOR THIS PARTICULAR PATIENT GIVEN THE PATIENT'S CLINICAL CONDITION	
PHYSICIAN SIGNATURE	DATE

## PATIENT AUTHORIZATION

I CERTIFY THAT I HAVE VOLUNTARILY PROVIDED A FRESH AND UNADULTERATED URINE SPECIMEN FOR ANALYTICAL TESTING. THE INFORMATION PROVIDED ON THIS FORM AND, ON THE LABEL, OFFERED TO THE SPECIMEN CUP 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