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PRACTICE INFORMATION

Patient Name_____

Date of Collection_____

Patient Initials_____

Collector's Name_____

1 PATIENT INFORMATION (Required)

LAST NAME FIRST NAME M.I.

HOME ADDRESS CITY ST ZIP PHONE

DATE OF BIRTH ○ M ○ F HEIGHT (in) WEIGHT (lbs)

2 BILLING INFO (Required)

○ Medicare ○ Medicaid ○ Workers' Compensation/ PIP (complete below) ○ Commercial ○ Client Billing ○ Self Pay

INSURANCE INFO _____

ADDITIONAL INFO (Required for all Workers Compensation or if no Insurance card is attached)

CASE # _____ DATE OF INJURY/ACCIDENT_____ EMPLOYER/ATTORNEY/ADJUSTER NAME _____ PH. #_____

3 DIAGNOSIS CODES (ICD required to highest level of specificity)

○ TDM (additional primary diagnosis required for Worker's Compensation)
w= Z79.899 Long-term (current) use of other medications

1 _____.____ 2 _____.____ 3 _____.

4 POINT OF CARE DRUG TEST

Time Collected:_____ AM/PM

Date Collected:_____

Collected by: _____

Temp chk within 4 min of col and its between 90 - 100ºF or 32 - 38ºC ☐ Yes ☐ No

POCT SCREENING PANEL

Pos.	Neg.		Pos.	Neg.		Pos.	Neg.		Pos.	Neg.	
☐	☐	AMP	☐	☐	COC	☐	☐	MTD	☐	☐	PCP
☐	☐	BAR	☐	☐	MDMA	☐	☐	OPI	☐	☐	TCA
☐	☐	BZO	☐	☐	MET	☐	☐	OXY	☐	☐	THC
☐	NO POCT Performed.					☐	☐	PPX	☐	☐	BUP

5 TESTS TO BE ORDERED & PRESCRIBED MEDICATIONS (Presumptive screening and validity is performed on all URINE samples, if no POCT performed)

☐ MEDICATION LIST ATTACHED
☐ MEDICATIONS: _____ _____ _____
☐ CHECK BOX TO OPT OUT OF CONFIRMATION TESTING ON POSITIVE SCREEN RESULTS
☐ U100 URINE PRESUMPTIVE (SCREENING) TESTING ONLY.
☐ U010 URINE ALL DRUGS - Definitive (Confirmation) Drug test on ALL DRUGS from the table below, except as marked with *
☐ U011 URINE POSITIVE ONLY - Definitive (Confirmation) Drug Test on POSITIVE Presumptive (screening) results and prescribed medication
☐ U012 URINE PAIN MANAGEMENT PANEL - Definitive Drug Testing (AMPs, BARBS, BENZOS, ILLICITS, OPIOIDS) and prescribed medication
☐ U013 URINE SUBSTANCE ABUSE PANEL - Definitive Drug Testing (OPIOIDS, ILLICIT, BENZOS, AMPs/STIMULANTS, RELAXANTS) and prescribed medication
☐ N001 ORAL FLUID PANEL ☐ Check box for ORAL FLUID SCREEN ☐ OTHER _____

SELECT DRUGS/PROFILES FROM THE LIST BELOW TO BE CONFIRMED BY LC/MS.

ORD	PRESC	Drug or Profile
		U100 IMMUNOASSAY SCREEN
		T106 OXYCODONE
		T108 AMPHETAMINES
		T109 OPIATES
		T110 COCAINE METABOLITE
		U010 URINE ALL DRUGS
		M004 OPIATES
		0019 Codeine
		0029 Morphine
		0024 Hydrocodone
		0025 Hydromorphone
		0021 Dihydrocodeine
		0064 Norhydrocodone
		M001 OXYCODONE PANEL
		0036 Oxycodone
		0037 Oxymorphone
		0065 Noroxycodone
		M006 FENTANYL/ANALOGS
		0023 Fentanyl
		0032 Norfentanyl
		0136 Acetyl-fentanyl
		0137 Carfentanyl
		0108 Sufentanil
		M040 PSYCHOACTIVES
		0138 Clozapine
		M010 BARBITURATES
		0008 Butalbital
		0009 Phenobarbital
		0072 Secobarbital
		M019 BATH SALTS
		0139 Ethylone

ORD	PRESC	Drug or Profile
		T111 BENZODIAZEPINES
		T112 THC
		T114 PCP
		M019 BATH SALTS (cont.)
		0140 Butylone
		0141 Methylone
		0142 Mephedrone
		0143 Pentedrone
		0069 MDPV
		M015 ECSTASY
		0005 MDA
		0076 MDEA
		0006 MDMA
		M038 SLEEP AIDS
		0146 Zolpidem COOH
		0062 Zaleplon
		0063 Zolpidem
		M018 OPIOIDS
		0030 Naloxone
		0035 O-Desmethyltramadol
		0026 Meperidine
		0017 Buprenorphine
		0041 Tramadol
		0033 Normeperidine
		0040 Tapentadol
		0107 Naltrexone
		0131 Naloxol
		0132 Beta-Naltrexol

ORD	PRESC	Drug or Profile
		T118 METHADONE
		T119 ETHYL GLUCURONIDE
		T121 BARBITURATES
		M018 OPIOIDS (cont.)
		0133 Destapentadol
		0031 Norbuprenorphine
		0113 Dextromethorphan
		0147 Dextrophan/Levorphanol
		M007 ANTIDEPRESSANT/SSRI
		0042 Amitriptyline
		0043 Desipramine
		0046 Nortriptyline
		0091 Doxepin
		0044 Imipramine
		0093 Trimipramine
		0048 Sertraline
		M003 BENZODIAZEPINES
		0074 Alprazolam
		Hydroxyalprazolam SALIVA ONLY
		0001 Alpha-hydroxyalprazolam
		0058 Clonazepam
		0002 7-AminoClonazepam
		0011 Diazepam
		0014 Nordiazepam
		0015 Oxazepam
		0016 Temazepam
		0055 Chlordiazepoxide
		0013 Lorazepam

ORD	PRESC	Drug or Profile
		U101 SPECIMEN VALIDITY
		T101 CREATININE
		T102 pH
		M003 BENZODIAZEPINES (cont.)
		0080 Midazolam
		Flunitrazepam SALIVA ONLY
		Flurazepam SALIVA ONLY
		0073 N-Desmethylflunitrazepam
		0010 DesalkylFlurazepam
		0127 Alpha-OH-Triazolam
		0129 OH-et-Flurazepam
		0128 Alpha-OH-Midazolam
		0145 7-AminoFlunitrazepam
		M009 ANTICONVULSANT
		0059 Gabapentin
		0038 Pregabalin
		M002 METHADONE PANEL
		0028 Methadone
		0022 EDDP
		M017 AMPHETAMINES/STIMULANTS
		0004 Amphetamine
		0007 Methamphetamine
		0045 Methylphenidate
		0047 Ritalinic Acid
		M016 ILLICITS
		0050 PCP
		Cocaine SALIVA ONLY
		0049 Benzoylecgonine (Cocaine)

ORD	PRESC	Drug or Profile
		T103 SPECIFIC GRAVITY
		T005 Oxidants/Bleach
		M016 ILLICITS (cont.)
		0130 Desomorphine
		0124 LSD
		0125 Mitragynine
		0003 6-MAM (Heroin)
		0126 7-Hydroxymitragynine
		THC SALIVA ONLY
		0051 THC COOH
		M023 SPICE
		0070 JWH-018 5-Pentanoic Acid
		0101 JWH-018 4-Hydroxypentyl
		0134 JWH-073 N-(3-hydroxybutyl)
		0135 JWH-250 5-Hydroxypentyl
		M037 ANESTHETICS
		0115 Ketamine
		0116 Norketamine
		M005 RELAXANTS
		0027 Meprobamate
		0018 Carisoprodol
		0060 Cyclobenzaprine
		M041 TOBACCO
		0144 Cotinine
		ALCOHOL
		ETG/ETS

PATIENT AUTHORIZATION (Required)

ertify that I have voluntarily provided a fresh and unadulterated urine specimen for analytical testing. The information provided on this form and on the label affixed to the specimen cup is accurate. I authorize Certivia Laboratories to release the results of this testing to the treating thorized healthcare provider or facility. I hereby authorize my insurance benefits to be paid directly to Certivia Laboratories for services I received. I understand that Certivia Laboratories may be an out-of-network provider with my insurer. I also understand that sometimes my insurance ll send the payment directly to me. I agree to endorse the insurance check and submit it to Certivia Laboratories immediately. Failure to send payment within 30 days of receipt could result in my account being turned over to collections and reported to the Credit Bureau.

Patient Signature:_____ Date:_____ CERTIVIA COPY

PHYSICIAN SIGNATURE (Required)

I authorize the above ordered test(s)

Authorized Healthcare Provider Signature:_____ Date:_____