FC 114000

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PEEL HERE — FC114000 — FC114000 — Date (Mo. - Day - Yr.) / / — Donor's Initials — PEEL HERE

FC114000
SPECIMEN ID NUMBER

13 PANEL POC TEST REQUISITION

PRACTICE INFORMATION

REQUESTING PHYSICIAN

DIAGNOSIS CODE(S)

PATIENT INFORMATION

LAST NAME | FIRST NAME | GENDER M ☐ F ☐

SSN | DATE OF BIRTH ___/___/___ | HEIGHT | WEIGHT

NAME OF INSURANCE

POLICY NUMBER

SPECIMEN INFORMATION

/ /
DATE COLLECTED

TIME COLLECTED

Temperature read within 4 minutes and is in range of 32.5 - 37.7°C (90.5 - 99.8°F)

☐ YES ☐ NO

If NO: Actual Temp

COLLECTOR'S NAME

A SELECT YOUR TESTING OPTION

☐ **USE Custom Profile;** perform additional tests, if ordered below **(1)**

☐ **NO POC Test Performed -** Lab to perform screen and confirm by quantification positive(s) and inconsistent negative(s).

FOR WORKERS COMP INDICATE

DATE OF INJURY ___/___/___

B RECORD POINT-OF-CARE RESULTS & ORDER TESTS

NOTE: If Point of-Care result is NOT marked it will default to a NEGATIVE result.

	RECORD POC TEST RESULTS POS (+)	RECORD POC TEST RESULTS NEG (–)	CONFIRM BY LCMS
AMP - AMPHETAMINE	☐	☐	☐
BAR - BARBITURATES	☐	☐	☐
BZO - BENZODIAZEPINES	☐	☐	☐
BUP - BUPRENORPHINE	☐	☐	☐
COC - COCAINE	☐	☐	☐
THC	☐	☐	☐
MET - METHAMPHETAMINE	☐	☐	☐
MDMA	☐	☐	☐
MOP - OPIATES	☐	☐	☐
MTD - METHADONE	☐	☐	☐
OXY - OXYCODONE	☐	☐	☐
PCP - PHENCYCLIDINE	☐	☐	☐
TCA - TRICYCLIC ANTIDEPRESSANTS	☐	☐	☐

C ORDER TESTS

Drug Name	ORDER SINGLE QUALITATIVE SCREEN	ORDER QUANTITATIVE CONFIRMATION
ALCOHOL	☐	—
CARISOPRODOL	—	☐
CATHINONES (Bath salts®)	—	☐
FENTANYL	—	☐
FLUOXETINE	—	☐
GABAPENTIN	—	☐
HEROIN	—	☐
MEPERIDINE	—	☐
METHYLPHENIDATE (Ritalin®)	—	☐
PAROXETINE	—	☐
PREGABALIN (Lyrica®)	—	☐
PROPOXYPHENE	☐	☐
SYNTHETIC CANNABINOIDS (Spice)	—	☐
TAPENTADOL	—	☐
TRAMADOL	—	☐
VENLAFAXINE (Effexor®)	—	☐
ZOLPIDEM (Ambien®)	—	☐

SPECIAL INSTRUCTIONS

D ORDER SPECIMEN VALIDITY TESTING

☐ **PERFORM Specimen Validity Testing** (Includes: Creatinine, pH, Specific Gravity and Nitrite) (Exclude the following tests):

☐ **DO NOT PERFORM Specimen Validity Testing**

E PATIENT'S PRESCRIBED MEDICATIONS

Indicating a medication is this section DOES NOT constitute a test request.

☐ **Medication list attached.**

☐ ACTIQ	☐ FENTANYL	☐ MORPHINE	☐ RESTORIL
☐ ADDERALL	☐ FENTORA	☐ MS CONTIN	☐ RITALIN
☐ ALPRAZOLAM	☐ FIORICET	☐ MSIR	☐ ROXICET
☐ AMBIEN	☐ FIORINAL	☐ NALOXONE	☐ ROXICODONE
☐ AMITRIPTYLINE	☐ FLEXERIL	☐ NALTREXONE	☐ SERAX
☐ ATIVAN	☐ FLUOXETINE	☐ NEURONTIN	☐ SOMA
☐ AVINZA	☐ GABAPENTIN	☐ NORCO	☐ SUBOXONE
☐ BUTRANS	☐ HYDROCODONE	☐ NORTRIPTYLINE	☐ SUBUTEX
☐ CHLORDIAZEPOXIDE	☐ HYDROCODONE/APAP	☐ NUCYNTA	☐ TAPENTADOL
☐ CLONAZEPAM	☐ HYDROMORPHONE	☐ OPANA	☐ TEMAZEPAM
☐ CYCLOBENZAPRINE	☐ KADIAN	☐ OXECTA	☐ TRAMADOL
☐ CYMBALTA	☐ KETAMINE	☐ OXYCODONE	☐ TYLOX
☐ DEMEROL	☐ KLONOPIN	☐ OXYCONTIN	☐ ULTRAM
☐ DIAZEPAM	☐ LORAZEPAM	☐ OXY IR	☐ VALIUM
☐ DILAUDID	☐ LORCET	☐ PAROXETINE	☐ VENLAFAXINE
☐ DURAGESIC	☐ LORTAB	☐ PAXIL	☐ VICODIN
☐ EFFEXOR	☐ LYRICA	☐ PERCOCET	☐ VICOPROFEN
☐ ELAVIL	☐ MEPERIDINE	☐ PREGABALIN	☐ XANAX
☐ EMBEDA	☐ METHADONE	☐ PRISTIQ	☐ ZOLPIDEM
☐ ENDOCET	☐ METHYLPHENIDATE	☐ PROZAC	

OTHER

INDICATE IF ANY OF THE FOLLOWING APPLY:

☐ Medicare ☐ Medicaid ☐ Commercial
☐ Worker's Compensation ☐ Self-Pay

PATIENT AUTHORIZATION

Consent/Insurance Release: I voluntarily consent to the collection and testing of my specimen and certify that the specimen identified on this form is my own and it is fresh and has not been adulterated in any manner. I certify that the information provided on this form and on the specimen bottle is accurate. I futher authorize the laboratory to release the results of this testing to the ordering facility. Futhermore, I hereby authorize my insurance benefits to be paid directly to First Choice Laboratory LLC for services which I receive. I acknowledge that the Lab may be an out-of-network facility within my insurance plan. I am also aware in some circumstances my insurance will send the payment directly to me for the service provided. Under law I agree to endorse the insurance check and forward it to the Lab within 30 days of receipt. Failure to do so could result in my account being forwarded to collections. By checking Self-Pay, I agree to be financially responsible for the tests.

Patient Signature: ***Date:***

PHYSICIAN SIGNATURE

Physician acknowledges that he/she has only ordered tests that were medically necessary and relevant to the above patient's care.

Physician Signature: ***Date:***

PLEASE COMPLETE ALL BLUE HIGHLIGHTED SECTIONS

SEE REVERSE SIDE FOR ADDITIONAL INFORMATION

ORIGINAL - FIRST CHOICE LABORATORY COPY CANARY - PHYSICIAN'S COPY PINK - PATIENT COPY

C-425487

(1) **If using Custom Profile, Physician must document medical necessity of test ordered in the patient's chart per patient encounter.** *Medicare defines any order(s) that does not specifically address an individual patient's unique illness, injury or medical status, as not reasonable and necessary.*