proventus
LAB SERVICES

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2 x 1 label
With barcode

BAR CODE

TOXICOLOGY TEST REQUISITION - URINE

REQUESTING PHYSICIAN

Physician Name / NPI:

Clinic Name:

Clinic Address:

SPECIMEN INFORMATION

Collected by (name):

Date and time collected:

ABN Needed?
Check box for "Yes" ☐

ABN Collected?
Check box for "Yes" ☐

PATIENT INFORMATION

REQUIRED: Enclose a copy of the front and back of patient's insurance card(s), driver's license, and patient demographic.

NEW PATIENT?
Check box for "Yes" ☐

☐ Insurance ☐ Medicare ☐ Physician / Client Bill
☐ Self Pay ☐ Workers Comp / Auto / LOP

LEGAL NAME

Last Name First Name Middle Initial

Address (city, state, zip)

Date of Birth Work Phone Home Phone

SSN Gender: ☐ Male ☐ Female

Guarantor

PRIMARY INSURANCE | SUBSCRIBER INFORMATION

Last Name First Name Middle Initial

Address (city, state, zip)

Date of Birth

Contract Number Policy Number

Group Number

DIAGNOSIS CODES *(Enter all that apply)*

RECORD POC RESULTS

	POS(+)	NEG(-)		POS(+)	NEG(-)		POS(+)	NEG(-)		POS(+)	NEG(-)		POS(+)	NEG(-)		POS(+)	NEG(-)		POS(+)	NEG(-)
Alcohol	☐	☐	Barbiturates	☐	☐	Buprenorphine	☐	☐	Heroin	☐	☐	Methadone	☐	☐	Opiates	☐	☐	Phencyclidine	☐	☐
Amphetamines	☐	☐	Benzodiazepines	☐	☐	Cocaine	☐	☐	MDMA	☐	☐	Methamphetamine	☐	☐	Oxycodone	☐	☐	THC	☐	☐

ORDER URINE FLUID DRUG TESTS *(Select only ONE box per test)*

☐ QUALITATIVE PRESUMPTIVE SCREENING

QUANTITATIVE (DEFINITIVE)		REFLEX
OPIATES/OPIOIDS	☐	☐ ☐
Buprenorphine/ Norbuprenorphine	☐	☐ ☐
Codeine	☐	
Morphine	☐	
Hydrocodone	☐	
Hydromorphone	☐	
Oxycodone/Noroxycodone	☐	☐ ☐
Oxymorphone	☐	— —
Meperidine/Normeperidine	☐	— —
Methadone	☐	
Methadone Metabolite (EDDP)	☐	
Naloxone	☐	— —
Fentanyl/Norfentanyl	☐	— —
Tramadol/N-Desmethyltramadol	☐	— —
BENZODIAZEPINES	☐	☐ ☐
Clonazepam/7-aminoclonazepam	☐	
Lorazepam	☐	
Alprazolam/A-hydroxyalprazolam	☐	
Diazepam/Nordiazepam	☐	
Oxazepam	☐	
Temazepam	☐	

QUANTITATIVE (DEFINITIVE)		REFLEX
SEDATIVES	☐	— —
Zolpidem	☐	— —
NICOTINIC AGONISTS	☐	— —
Cotinine (Nicotine Metabolite)	☐	— —
BARBITURATES	☐	☐ ☐
Butalbital	☐	— —
Pentobarbital	☐	— —
Phenobarbital	☐	— —
Secobarbital	☐	— —
CANNABIS-DERIVED	☐	☐ ☐
THC-11-nor delta 9 carboxy	☐	☐ ☐
NEUROPATHIC PAIN	☐	— —
Gabapentin	☐	— —
Pregabalin	☐	— —
MUSCLE RELAXANTS	☐	— —
Carisoprodol/Meprobamate	☐	— —

QUANTITATIVE (DEFINITIVE)		REFLEX
STIMULANTS	☐	☐ ☐
Methylphenidate	☐	— —
Amphetamine	☐	
Methamphetamine	☐	
PROPOXYPHENE	☐	
Propoxyphene/Norpropoxyphene	☐	— —
ALCOHOL	☐	☐ ☐
EtS	☐	
EtG	☐	
ANESTHETIC	☐	— —
Ketamine/Norketamine	☐	— —
ILLICIT DRUGS	☐	☐ ☐
Benzoylecgonine (Cocaine Metabolite)	☐	☐ ☐
MDA	☐	— —
MDMA	☐	— —
Mitragynine/7-hydroxymitragynine	☐	— —
PCP	☐	— —
LSD	☐	— —
Psilocin	☐	— —
Xylazine/4-hydroxy xylazine	☐	— —
6-acetylmorphine (Heroin Metabolite)	☐	☐ ☐

PRESCRIBED MEDICATIONS *(Select below)*

☐ Abilify	☐ Hydromorphone	☐ Percocet
☐ Adderall	☐ Imipramine	☐ Pregabalin
☐ Alprazolam	☐ Klonopin	☐ Prozac
☐ Ambien	☐ Lexapro	☐ Quetiapine
☐ Amitriptyline	☐ Lyrica	☐ Restoril
☐ Buprenorphine	☐ Meperidine	☐ Ritalin
☐ Bupropion	☐ Methadone	☐ Serax
☐ Butrans	☐ Methylphenidate	☐ Seroquel
☐ Clonazepam	☐ Morphine	☐ Sertraline
☐ Cymbalta	☐ Ms Contin	☐ Soma
☐ Demerol	☐ Naloxone	☐ Suboxone
☐ Desipramine	☐ Neurontin	☐ Tapentadol
☐ Diazepam	☐ Norco	☐ Temazepam
☐ Dilaudid	☐ Nortriptyline	☐ Tramadol
☐ Duloxetine	☐ Nucynta	☐ Trazodone
☐ Effexor	☐ Opana	☐ Valium
☐ Fentanyl	☐ Oxazepam	☐ Venlafaxine
☐ Fioricet	☐ Oxycodone	☐ Vicodin
☐ Fluoxetine	☐ Oxycontin	☐ Wellbutrin
☐ Gabapentin	☐ Oxymorphone	☐ Xanax
☐ Haldol	☐ Paroxetine	☐ Zoloft
☐ Hydrocodone	☐ Paxil	☐ Zolpidem

ADDITIONAL MEDICATIONS LIST

SPECIMEN VALIDITY TESTS *(INCLUDED)*

☑ Creatine ☑ Oxidants ☑ pH ☑ Specific Gravity

MEDICAL NECESSITY CERTIFICATION *(REQUIRED)*

All orders must be supported be medical necessity as documented in an individual file. Completion of all sections and provider signature are required for test order.

☐ Patient history
☐ Physical examination
☐ Previous laboratory findings
☐ Current treatment plan
☐ Prescribed medication(s)
☐ Historical use
☐ Community trends
☐ Stage of treatment or recovery
☐ Suspected abused substance
☐ Risk for addiction or drug interaction

☐ Safety risks attendant to failure to identify speifics substances

☐ Office performed presumptive UDT (POCT or EIA)

☐ Differential assessment of medication efficacy, side effects or drug-drug interactions

☐ Definitive concentration needed to guide management

Risk Assessment: ☐ Low ☐ Moderate ☐ High

PATIENT SIGNATURE - MUST BE COMPLETED

I authorize my insurance benefits to be paid directly to Proventus Lab Services for performing this service. I understand that I am responsible for any remaining balance. This authorization includes the release of any private health information necessary for billing to the testing laboratory as well as any entity they may utilize for billing purposes. I further authorize the release of the testing results to my ordering physician. I also understand that Proventus Lab Services may refer a portion or all of the testing requested per this form to a similarly capable laboratory and I authorize that laboratory to bill my insurance accordingly.

PATIENT SIGNATURE DATE

PRACTITIONER SIGNATURE - MUST BE COMPLETED

Information has been provided to the patient about the test(s) to be performed, and the patient has given consent for the test(s) to be performed, as required by applicable law. I confirm the test(s) are medically necessary. I am listed as the Requesting Physician authorized by law to order the test(s) requested herein.

PRACTITIONER SIGNATURE DATE