Shepard Health

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ORAL FLUID TOXICOLOGY

Ordering Physician: ______________________ Name of Practice: ______________________

Date: ____/____/______ Address: ______________________

ICD Code(s)

____

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Ordering Physician Signature

Patient Information:

Last Name: ______________ First Name: ______________ MI: ____ Address: ______________

City: ______________ State: ______________ Zip Code: ______________ Phone #: ______________

DOB: ____/____/______ Sex: ☐ M ☐ F ☐ Insurance: ______________________ ☐ Self-Pay

*INCLUDE COPY OF INSURANCE CARD

☐ **NO PRESCRIBED MEDICATIONS** ☐ **MEDICATION PRESCRIBED** (ATTACH PATIENT'S MEDICATION LIST OR LIST BELOW)

Prescribed Medication(s): ______________________

I CERTIFY THAT I HAVE PROVIDED MY SPECIMEN TO THE COLLECTOR, THAT I HAVE NOT ADULTERATED IT IN ANY MANNER, AND THAT THE INFORMATION PROVIDED ON THIS FORM AND ON THE LABEL AFFIXED TO EACH SPECIMEN IS CORRECT. I AUTHORIZE THE RELEASE OF THE RESULTS TO THE ORDERING CLINICIAN & STAFF. I AUTHORIZE HELIOSDX LABS TO RELEASE ANY INFORMATION REQUIRED FOR BILLING PURPOSES. I AUTHORIZE PAYMENT DIRECTLY TO HELIOSDX. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR PAYMENTS SHOULD INSURANCE BE DENIED, PARTIALLY PAID OR CO-PAYMENTS REQUIRED.

Patient Signature: ______________________ Date: ____/____/______

Date and Time of Collection: ____/____/______ ______:______ Collector Initials: ______________

*ALL URINE SAMPLES MUST HAVE PATIENT'S NAME AND DATE OF BIRTH ON CUP

POC Test Results

☐ POC Testing was NOT performed.

☐ Initial drug screen was performed and will be billed at the provider's office.

POC Screening:

- ☐ Amphetamines
- ☐ Barbiturates
- ☐ Benzodiazepines
- ☐ Buprenorphine
- ☐ Cocaine
- ☐ MDMA
- ☐ Methadone
- ☐ Methamphetamines
- ☐ Opiates
- ☐ Oxycodone
- ☐ PCP
- ☐ THC
- ☐ Tricyclic Antidepressants (TCA)
- ☐ Other1: ______________
- ☐ Other2: ______________

ORAL FLUID TOXICOLOGY TEST MENU

DISCLAIMER: *Per CMS's National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits, presumptive testing cannot be reported with confirmation testing for samples collected on the same date of service. Test A. and B. provided on this requisition cannot be selected simultaneously.*

TEST OPTION

☐ Oral Fluid Panel - Definitive Drug Testing (on all drugs listed below)

ORAL FLUID DRUG PANEL

☐ **Amphetamines**
- ☐ Amphetamine

☐ **Anticonvulsants**
- ☐ Gabapentin
- ☐ Pregabalin

☐ **Benzodiazepines**
- ☐ 7-Aminoclonazepam
- ☐ Alpha-Hydroxyalprazolam
- ☐ Alprazolam
- ☐ Clonazepam
- ☐ Diazepam
- ☐ Lorazepam
- ☐ Nordiazepam
- ☐ Oxazepam
- ☐ Temazepam

☐ **Illicit Drugs**
- ☐ 6-MAM
- ☐ Benzoylecgonine
- ☐ MDA
- ☐ MDEA
- ☐ MDMA
- ☐ Methamphetamine
- ☐ PCP

☐ **Opiates/Opioids**
- ☐ Buprenorphine
- ☐ Codeine
- ☐ Fentanyl
- ☐ Hydrocodone
- ☐ Hydromorphone
- ☐ Morphine
- ☐ Norbuprenorphine
- ☐ Norfentanyl
- ☐ Oxycodone
- ☐ Oxymorphone
- ☐ Propoxyphene

☐ **Opioid Agonists/Antagonists**
- ☐ EDDP
- ☐ Methadone
- ☐ Naloxone

☐ **Relaxants / Sleep Aids**
- ☐ Carisoprodol
- ☐ Meprobamate

☐ **THC - Cannabinoids**
- ☐ Delta 9 THC

MEDICAL NECESSITY (If not marked, specimen will be returned)

☐ Best Practices - Testing for drugs of abuse and adherence to the treatment plan is a recognized best practices component of proper management when COT is involved. Valid risk assessment and PMP are noted in patient medical records.

☐ Other: ______________________