

Ordering Physician: \_\_\_\_\_ Name of Practice: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_ Address: \_\_\_\_\_

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 SHEPARD HEALTH TO RELEASE ANY INFORMATION REQUIRED FOR BILLING PURPOSES. I AUTHORIZE PAYMENT DIRECTLY TO SHEPARD HEALTH. 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

**URINE 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.

**PRELIMINARY URINE DRUG SCREEN**

Check here for urine drug screen (includes: amphetamine, barbiturates, benzodiazepines, buprenorphine, cannabinoid, cocaine, creatinine, EtOH, methadone, nicotine, opiate, oxycodone, & pH)

**LCMS CONFIRMATORY TESTING**

Check here to test for all drug classes listed below:

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> <b>Anticonvulsants/Antipsychotics</b><br><input type="checkbox"/> Gabapentin <input type="checkbox"/> Risperidone<br><input type="checkbox"/> Pregabalin  | <input type="checkbox"/> <b>Illicit Drugs</b><br><input type="checkbox"/> 6-MAM <input type="checkbox"/> MDMA<br><input type="checkbox"/> Benzoylcegonine <input type="checkbox"/> Methamphetamine<br><input type="checkbox"/> Flunitrazepam <input type="checkbox"/> PCP<br><input type="checkbox"/> MDA <input type="checkbox"/> THC<br><input type="checkbox"/> MDEA | <input type="checkbox"/> <b>Opiates/Opioids</b><br><input type="checkbox"/> Buprenorphine<br><input type="checkbox"/> Codeine<br><input type="checkbox"/> Fentanyl<br><input type="checkbox"/> Hydrocodone<br><input type="checkbox"/> Hydromorphone<br><input type="checkbox"/> Meperidine<br><input type="checkbox"/> Morphine<br><input type="checkbox"/> N-Desmethyhtapentadol<br><input type="checkbox"/> Norbuprenorphine<br><input type="checkbox"/> Norfentanyl<br><input type="checkbox"/> Norhydrocodone<br><input type="checkbox"/> Normeperidine<br><input type="checkbox"/> Noroxycodone<br><input type="checkbox"/> O-Desmethyltramadol<br><input type="checkbox"/> Oxycodone<br><input type="checkbox"/> Oxymorphone<br><input type="checkbox"/> Propoxyphene<br><input type="checkbox"/> Tramadol | <input type="checkbox"/> <b>Stimulants</b><br><input type="checkbox"/> Amphetamine<br><input type="checkbox"/> Methylphenidate<br><input type="checkbox"/> Phentermine<br><input type="checkbox"/> Ritalinic Acid |
| <input type="checkbox"/> <b>Antidepressants/Anti-Anxiety</b><br><input type="checkbox"/> Amitriptylin <input type="checkbox"/> Nortriptyline<br><input type="checkbox"/> Duloxetine <input type="checkbox"/> Sertraline<br><input type="checkbox"/> Fluoxetine <input type="checkbox"/> Venlafaxine<br><input type="checkbox"/> Imipramine | <input type="checkbox"/> <b>Muscle Relaxants</b><br><input type="checkbox"/> Carisoprodol <input type="checkbox"/> Meprobamate<br><input type="checkbox"/> Cyclobenzaprine  | <input type="checkbox"/> <b>Narcotic Pain Relievers</b><br><input type="checkbox"/> Norpropoxyphene   | <input type="checkbox"/> <b>Opiate (Narcotic) Analgesics</b><br><input type="checkbox"/> Tapentadol   |
| <input type="checkbox"/> <b>Barbiturates</b><br><input type="checkbox"/> Butalbital <input type="checkbox"/> Phenobarbital   | <input type="checkbox"/> <b>Opioid Agonists/Antagonists</b><br><input type="checkbox"/> EDDP <input type="checkbox"/> Naloxone<br><input type="checkbox"/> Methadone <input type="checkbox"/> Naltrexone  | <input type="checkbox"/> <b>Tricyclic Antidepressants (TCA)</b><br><input type="checkbox"/> Doxepin   |   |

Add reflex testing for:  
D & L Methamphetamine (Chiral Tessing)

**TOX DIAGNOSIS CODES (REQUIRED)**

- Z51.81: Encounter for therapeutic drug level monitoring
- M54.5 Low back pain
- F19.20 Other psychoactive substance dependence, uncomplicated
- G89.4 Chronic pain syndrome
- F11.20 Opioid dependence, unspecified
- F90.9 A.D.D.
- M54.2 Cervicalgia
- Z79.899 Other long term (current) drug therapy
- G89.29 Other chronic pain
- Z79.891 Long-term (current) use of opiate analgesic
- Additional ICD 10 Codes: \_\_\_\_\_

**URINARY ANALYSIS & PCR TESTING**

**Complete Urinalysis Screen + Reflex to UTI PCR Testing**

(Includes 10-parameter strip and reflex to microscopy and PCR, if necessary)

10-parameter strip + macroscopic inspection.

\*Sample will reflex to microscopic inspection if positive for nitrite, leukocytes, blood, and/or abnormal appearance.

\*\*If microscopic analysis detects the presence of bacteria, WBCs, yeast, and/or parasites, reflex the urine sample to Comprehensive UTI + ABX Resistance testing.

**Comprehensive UTI + ABX Resistance**

Detectable Pathogens:

- |                         |                           |                             |                              |
|-------------------------|---------------------------|-----------------------------|------------------------------|
| Acinetobacter baumannii | Corynebacterium riegellii | Neisseria gonorrhoeae       | Staphylococcus lugdunensis   |
| Bacteroides vulgatus    | Enterococcus faecium      | Prevotella bivia            | Staphylococcus saprophyticus |
| Candida albicans        | Enterobacter aerogenes    | Proteus mirabilis           | Staphylococcus warneri       |
| Candida auris           | Enterobacter cloacae      | Proteus vulgaris            | Streptococcus agalactiae     |
| Candida dubliniensis    | Enterococcus faecalis     | Providencia stuartii        | Streptococcus pyogenes       |
| Candida glabrata        | Escherichia coli          | Pseudomonas aeruginosa      | Trichomonas vaginalis        |
| Candida parapsilosis    | Klebsiella oxytoca        | Serratia marcescens         | Ureaplasma urealyticum       |
| Chlamydia trachomatis   | Klebsiella pneumoniae     | Staphylococcus aureus       | Viridans Group Strep         |
| Citrobacter freundii    | Morganella morganii       | Staphylococcus epidermidis  |                              |
| Citrobacter koseri      | Mycoplasma hominis        | Staphylococcus haemolyticus |                              |

**Parameters Tested on Urine Strips:**

- Leukocytes
- Nitrite
- Urobilinogen
- Protein
- pH
- Blood
- Specific Gravity
- Ketone
- Bilirubin
- Glucose

**Additional Urine Testing**

Add Microalbumin, Creatinine, and Ratio.

**URINARY ANALYSIS & UTI CODES (REQUIRED)**

- R39.9: Lower urinary tract symptoms
- R10.9: Unspecified abdominal pain
- R30.9: Difficulty or pain in urination
- R35.0: Increased frequency of urination
- N39.0: Urinary tract infection, site not specified
- R82.7: Abnormal findings on microbiological examination of urine.
- R82.90: Unspecified abnormal findings in urine
- Other primary: \_\_\_\_\_

**Release and Consent:** As a courtesy, Shepard Health, LLC makes every reasonable effort to obtain reimbursement for ordered tests. I authorize Shepard Health, LLC to release to Medicare, it's carriers, and any insurance carrier or health plan providing benefits to me, any information that may be needed for claim purpose. I am making an assignment of Medicare, Medicaid, and/or insurance benefits to Shepard Health, LLC. I understand if my insurance company pays me directly for services rendered by Shepard Health, LLC, I am responsible for forwarding such and all payments directly to Shepard Health, LLC. I also understand and agree to that I am responsible for any copayment and/or deductible, as required by my plan.