Org ID #: 00_______
*Organization Name: ___________________________

*Organization Address: ________________________

*City: ________________*St._____*Zip:___________

*Phone:________________*Fax:________________

*Order Provider: ______________________________

Please print. Use full provider name, no nicknames or initals
***All information required for valid order**
Label specimen with 2 patient identifiers (full name and date of birth).

Provider signature ________________________________

Additional report to: Provider ____________________ Fax ______________

Order comment ____________________________________

SPECTRUM HEALTH

LABORATORY REQUISITION TOXICOLOGY

*Date Ordered	*Date Collected	*Time Collected	*Initials Collected

***ORDER EXPIRATION**

☐ 60 days ☐ 90 days ☐ 180 days ☐ 365 days
Note: No indication of order expiration date will default to 400 days
Standing Orders: ☐ Weekly ☐ Monthly ☐ As needed ☐ Other__________

***PATIENT INFORMATION**

Name: Last First Middle Init.

Address | Phone

City | State | Zip

Sex	Marital Status	Birth Date	Cell Phone

***DIAGNOSIS/ICD CODES**

1st ________________
2nd ________________
Other ________________
Other ________________

***INSURANCE INFORMATION**

Providers submitting SPECIMEN orders attach copy(s) of insurance cards (front and back). Indicate Primary and Secondary.

COLLECTOR CONTROL LABEL (IF APPLICABLE)	SPECTRUM HEALTH LABORATORY USE ONLY	ADDITIONAL NOTES

TEST(S) ORDERED

4008 ☐ **Drug Screen Abuse Toxicology*** - Amphetamines, Barbiturates, Benzodiazepines, Cannabinoids, Cocaine, Methadone, Opiates, Oxycodone, PCP, Ethanol, Adulterants
4009 ☐ **Drug Screen Pain Management*** - Amphetamines, Barbiturates, Benzodiazepines, Cannabinoids, Cocaine, Ethanol, Methadone, Adulterants, Plus LCMS Confirmation of Opiates (Codeine, Morphine, Hydrocodone, Hydromorphone, Oxycodone, Oxymorphone, 6 MAM)
4095 ☐ **Drug Screen Low Risk Pain Management*** - Amphetamines, Cannabinoids, Cocaine, Ethanol, Adulterants, Plus LCMS Confirmation of Opiates (Codeine, Morphine, Hydrocodone, Hydromorphone, Oxycodone, Oxymorphone, 6 MAM), Methadone, Tramadol

*Is GCMS confirmation of positive screen results requested? ☐ Yes ☐ No
(There will be an additional cost per drug confirmed)

502 ☐ GCMS Amphetamines
515 ☐ GCMS Cannabinoids
506 ☐ GCMS Ethanol
510 ☐ GCMS Methadone
503 ☐ GCMS Barbiturates
505 ☐ GCMS Cocaine
516 ☐ GCMS Fentanyl
513 ☐ GCMS Phencyclidine
507 ☐ GCMS Expanded Amphetamines (MDMA, MDA)
508 ☐ GCMS Expanded Benzodiazepines (Oxazepam, Lorazepam, Alprazolam, Clonazepam, Nordiazepam, Temazepam))
509 ☐ LCMS Expanded Opiates (6 MAM, codeine, hydrocodone, hydromorphone, morphine, oxycodone, oxymorphone)
8903 ☐ Buprenorphine conf.
8998 ☐ Synthetic Cannabinoids (Spice/K2)
997 ☐ Methylphenidate conf.
999 ☐ Tapentadol conf.
801 ☐ Tramadol conf.

SPECIMEN INTEGRITY

Bluing agent in bowl? ☐ Yes ☐ No
Dry toilet used? ☐ Yes ☐ No
Hand washing prior to collection? ☐ Yes ☐ No
Urine temperature in range? ☐ Yes ☐ No
(32.5° C - 37.7° C/90.5° F - 99.8° F)
Temperature taken within 4 minutes of collection? ☐ Yes ☐ No

COLLECTOR REMARKS

____
____
____
____

MEDICATIONS **Used Within (check one)**

________________ ☐ 72 hours ☐ 14 days
________________ ☐ 72 hours ☐ 14 days
________________ ☐ 72 hours ☐ 14 days
________________ ☐ 72 hours ☐ 14 days

DOCUMENTATION

Donor - Read and Sign: I hereby give permission for collection of my urine and acknowledge that it is my own. Further, I attest that the sample was sealed in my presence prior to forwarding for laboratory analysis.

Date __________ Donor signature ***(required)*** ____________________

Collector - Read And Sign: I certify that the specimen identified on this form is the specimen presented to me by the donor and that it has been collected, labeled, and sealed according to applicable drug testing criteria.

Date __________ Collector signature ***(required)*** ____________________ Collector name ***(print)*** ____________________

CHAIN OF CUSTODY

REASON FOR CHANGE	RELEASED FROM	RELEASED TO	DATE
To provide specimen	Donor	X	X
Transport	X	Secure package	X
Received in Toxicology Lab	Secure package	X	X

NOTE: FOR MEDICARE PATIENTS, ATTACH COMPLETED ABN FORM CMS-R 131 AS NEEDED. SPECTRUM HEALTH LABORATORY SERVICES 616.774.7721

White – Toxicology **Yellow – Lab Central** **Pink – Collector** **Gold – Patient/Donor**

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.