

MUST COMPLETE ALL GREEN HIGHLIGHTED SECTIONS

PATIENT INFORMATION

PRACTICE INFORMATION

Last Name _____ First Name _____ MI _____ Facility/Group _____ Referring Physician _____
 Social Security: _____ - _____ - _____ Male Female _____
 Date of Birth (m/d/y) _____ Address _____ NPI Provider Nr. _____
 Address _____
 Address _____
 Self-Pay (attach Information) Commercial Insurance (attach copy) W/C (Date of Injury): _____ Medicare (attach copy of Insurance Card)

I certify that I have voluntarily provided a fresh unadulterated urine specimen/oral fluid for analytical testing. The information provided on this form and on the label affixed to the specimen bottle is accurate. I authorize lab to release the results of this testing to the ordering physician. I also authorize lab to bill my insurance provider and to receive payment of benefits for the tests ordered by my physician. I further authorize lab and the ordering physician to release to my insurance provider any medical information necessary to process this claim. I acknowledge that lab may be an out-of-network facility with my insurance provider.

Patient Signature (or Legal Guardian): _____ Date: _____

TEST PANELS / PRESCRIBED MEDICATION (please check desired panels):

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> 1. NARCOTIC ANALGESICS / OPIOIDS / OPIATES
<input type="checkbox"/> Acetaminophen (Tylenol)
<input type="checkbox"/> Buprenorphine (Butrans, Suboxone)
<input type="checkbox"/> Butorphanol (Stadol)
<input type="checkbox"/> Codeine (Tylenol #3)
<input type="checkbox"/> Fentanyl (Duragesic, Actiq)
<input type="checkbox"/> Hydrocodone (Norco, Vicodin)
<input type="checkbox"/> Hydromorphone (Dilaudid)
<input type="checkbox"/> Ketamine (Ketalar)
<input type="checkbox"/> Levorphanol (Levo-Dromoran)
<input type="checkbox"/> Meperidine (Demerol)
<input type="checkbox"/> Methadone (Methadose, Dolophine)
<input type="checkbox"/> Morphine (MS Contin, Kadian, Duramorph, Avinza)
<input type="checkbox"/> Oxycodone (Percocet, Roxicet, Oxycontin, Endocet)
<input type="checkbox"/> Oxymorphone (Opana)
<input type="checkbox"/> Propoxyphene (Darvon)
<input type="checkbox"/> Tapentadol (Nucynta)
<input type="checkbox"/> Tramadol (Ultram) | <input type="checkbox"/> Clozapine (Clozaril)
<input type="checkbox"/> Fluphenazine (Permitil)
<input type="checkbox"/> Haloperidol (Haldol)
<input type="checkbox"/> Olanzapine (Zyprexa)
<input type="checkbox"/> Quetiapine (Seroquel)
<input type="checkbox"/> Risperidone (Risperdal)
<input type="checkbox"/> Thioridazine (Mellaril)
<input type="checkbox"/> Ziprasidone (Geodon) | <input type="checkbox"/> Levetiracetam (Keppra)
<input type="checkbox"/> Oxcarbazepine (Trileptal)
<input type="checkbox"/> Pregabalin (Lyrica)
<input type="checkbox"/> Tiagabine (Gabitril)
<input type="checkbox"/> Valproic Acid (Depakote)
<input type="checkbox"/> Zonisamide (Zonegran) | <input type="checkbox"/> Mephedrone (Bath Salts)
<input type="checkbox"/> Methamphetamine (Meth)
<input type="checkbox"/> Methylone (Bath Salts)
<input type="checkbox"/> Mitragynine (Kratom)
<input type="checkbox"/> PCP (Phencyclidine)
<input type="checkbox"/> THC (Marijuana)
<input type="checkbox"/> U-47700 (Nor-U-47700, N-Desmethyl-U-47700 - Synthetic Opioid) |
| <input type="checkbox"/> 2. BENZODIAZEPINES
<input type="checkbox"/> Alprazolam (Xanax, Niravam)
<input type="checkbox"/> Chlordiazepoxide (Librium)
<input type="checkbox"/> Clobazam (Onfi)
<input type="checkbox"/> Clonazepam (Klonopin)
<input type="checkbox"/> Diazepam (Valium, Diastat)
<input type="checkbox"/> Estazolam (Prosom)
<input type="checkbox"/> Flunitrazepam (Rohypnol)
<input type="checkbox"/> Lorazepam (Ativan)
<input type="checkbox"/> Oxazepam (Serax)
<input type="checkbox"/> Prazepam (Centrac)
<input type="checkbox"/> Temazepam (Restoril)
<input type="checkbox"/> Triazolam (Halcion) | <input type="checkbox"/> 4. ANTI-DEPRESSANTS / SSRI / SNRI / TCA
<input type="checkbox"/> Amitriptyline (Elavil)
<input type="checkbox"/> Bupropion (Wellbutrin)
<input type="checkbox"/> Citalopram (Celexa)
<input type="checkbox"/> Clomipramine (Anafranil)
<input type="checkbox"/> Desipramine (Norpramin)
<input type="checkbox"/> Desvenlafaxine (Pristiq)
<input type="checkbox"/> Doxepin (Silenor, Prudoxin)
<input type="checkbox"/> Duloxetine (Cymbalta)
<input type="checkbox"/> Fluoxetine (Prozac)
<input type="checkbox"/> Fluvoxamine (Luvox)
<input type="checkbox"/> Imipramine (Tofranil)
<input type="checkbox"/> D-L-Kavain, Yalongin, Methysticin (Kava)
<input type="checkbox"/> Mirtazapine (Remeron)
<input type="checkbox"/> Nortriptyline (Pamelor)
<input type="checkbox"/> Paroxetine (Paxil, Pexeva)
<input type="checkbox"/> Sertraline (Zoloft)
<input type="checkbox"/> Trazodone (Oleptro)
<input type="checkbox"/> Venlafaxine (Effexor) | <input type="checkbox"/> 7. MUSCLE RELAXANTS
<input type="checkbox"/> Baclofen (Lioresal)
<input type="checkbox"/> Carisoprodol (Soma)
<input type="checkbox"/> Cyclobenzaprine (Flexeril) | <input type="checkbox"/> SPICE CANNABINOIDS
<input type="checkbox"/> 5-Fluoro NPB-22
<input type="checkbox"/> AB-FUBINACA
<input type="checkbox"/> AM-2201
<input type="checkbox"/> FDU-PB-22
<input type="checkbox"/> HU-210
<input type="checkbox"/> JWH-019
<input type="checkbox"/> JWH-073-4-Hydroxybutyl
<input type="checkbox"/> JWH-081
<input type="checkbox"/> JWH-122
<input type="checkbox"/> JWH-18-5-Pentonic Acid
<input type="checkbox"/> JWH-18-5-Pentanyl
<input type="checkbox"/> JWH-250-5-OH-Pentanyl
<input type="checkbox"/> MMB-CHMICA |
| <input type="checkbox"/> 3. ANTI-PSYCHOTICS
<input type="checkbox"/> Aripiprazole (Abilify)
<input type="checkbox"/> Chlorpromazine (Thorazine) | <input type="checkbox"/> 5. DEPRESSANTS
<input type="checkbox"/> Flurazepam (Dalmane)
<input type="checkbox"/> Midazolam (Versed)
<input type="checkbox"/> Zaleplon (Sonata)
<input type="checkbox"/> Zolpidem (Ambien)
<input type="checkbox"/> Zopiclone (Zimovane, Lunesta) | <input type="checkbox"/> 8. STIMULANTS
<input type="checkbox"/> Amphetamine (Adderall)
<input type="checkbox"/> Caffeine (Viviran, Cafcit)
<input type="checkbox"/> Ephedrine (Bronkaid)
<input type="checkbox"/> Methylphenidate (Ritalin)
<input type="checkbox"/> Lisdexamphetamine (Vyvanse)
<input type="checkbox"/> Ritalinic Acid (Methylphenidate) | <input type="checkbox"/> 13. BARBITURATES
<input type="checkbox"/> Amobarbital (Amytal)
<input type="checkbox"/> Butobarbital (Butisol)
<input type="checkbox"/> Butalbital (Axotal)
<input type="checkbox"/> Phenobarbital (Luminal)
<input type="checkbox"/> Pentobarbital (Nembutal)
<input type="checkbox"/> Secobarbital (Seconal) |
| <input type="checkbox"/> 6. ANTI-CONVULSANTS
<input type="checkbox"/> Carbamazepine (Tegretol)
<input type="checkbox"/> Gabapentin (Neurontin)
<input type="checkbox"/> Lamotrigine (Lamictal) | <input type="checkbox"/> 9. DECONGESTANTS
<input type="checkbox"/> Dextromethorphan (Robitussin)
<input type="checkbox"/> Pseudoephedrine (Sudafed) | <input type="checkbox"/> 10. APPETITE STIMULANT
<input type="checkbox"/> Marinol (Dronabinol Extract)
<input type="checkbox"/> Phentermine (Suprenza) | <input type="checkbox"/> 14. DIRECT BIOMARKERS
<input type="checkbox"/> Cotinine (Nicotine)
<input type="checkbox"/> ETG (Ethanol Metabolite)
<input type="checkbox"/> ETS (Ethanol Metabolite) |
| <input type="checkbox"/> 11. ANTIDOTES
<input type="checkbox"/> Naloxone (Reviv, Vivitrol)
<input type="checkbox"/> Naltrexone (Evzio) | <input type="checkbox"/> 12. ILLICITS
<input type="checkbox"/> 6-MAM (Heroin)
<input type="checkbox"/> Acetyl-Fentanyl
<input type="checkbox"/> Alpha-PVP ("Flakka")
<input type="checkbox"/> Carfentanil (Wildnil®)
<input type="checkbox"/> Cocaine ("Coke")
<input type="checkbox"/> DMT (Tryptamine, Psilocybin)
<input type="checkbox"/> MDA (Tenamfetamine)
<input type="checkbox"/> MDEA ("Eve")
<input type="checkbox"/> MDMA (Ecstasy, "Molly")
<input type="checkbox"/> MDPV (Bath Salts) | <input type="checkbox"/> NO MEDICATION PRESCRIBED | |

SAMPLE HANDLING

Time Collected: _____ AM/PM Date Collected: _____
 Collected by: _____
 The following **MUST** be completed (check all that apply):
 Medication List OR desired Drug Panels marked above.
 Minimum of 5 mL specimen provided in Urine Test Cup or
 MedMap blood test sample by dried blood spot on paper card.
 Sample sealed tightly bagged in BIOHAZARD bag without spill or exposure.

AUTHORIZATION & ATTESTATION

By signing below, I authorize Alcala Testing to perform LC-MS/MS testing for qualitative and quantitative confirmation of positive and negative results. I attest that the requested testing is medically necessary and appropriate based on the patient's diagnosis and treatment plan. I have personally completed the diagnosis codes above to indicate the accurate diagnosis for this patient. I have not already provided this testing on the date of collection.

Physician Signature: _____ Date: _____