Alcala LABS

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ACCESSION STICKER HERE

PRACTICE INFORMATION

Referring Physician:

MUST COMPLETE ALL GREEN HIGHLIGHTED SELECTIONS

PATIENT INFORMATION

_____ _____ _____
Last Name First Name MI

_____/_____/_____ Social Security: _____-_____-_____ ☐ Male ☐ Female
Date of Birth

☐ Self-Pay ☐ Commercial Insurance ☐ W/C: (Date of Injury): _____ ☐ Medicare

***DX CODES (ICD 10)*:** _____ _____ _____

I certify that I have voluntarily provided a fresh unadulterated urine specimen/oral fluid specimen for analytical testing. The information provided on this form and on the label affixed to the specimen cup 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: _____ Date: _____

TEST PANELS (please check desired drugs/drug classes for testing):

☐ **TEST FOR ALL CLASSES BELOW (1-10):**

☐ **1. NARCOTIC ANALGESICS / OPIATES**
- o Acetaminophen (*Tylenol*)
- o Buprenorphine (*Butrans, Suboxone*)
- o Codeine (*Tylenol #3*)
- o Fentanyl (*Duragesics*)
- o Hydrocodone (*Norco, Vicodin*)
- o Hydromorphone (*Dilaudid*)
- o Levorphanol (*Levo-Dromoran*)
- o Meperidine *(Demerol)*
- o Methadone (*Methadose)*
- o Morphine (*MS Contin*)
- o Tramadol (*Ultram*)
- o Oxycodone (*Percocet,Oxycontin*)
- o Oxymorphone (*Opana*)
- o Propoxyphene (*Darvon*)
- o Tapentadol (*Nucynta*)

☐ **2. BENZODIAZEPINES**
- o Alprazolam (*Xanax, Xanax XR)*
- o Clonazepam (*Klonopin*)
- o Diazepam (*Valium, Diastat*)
- o Lorazepam (*Ativan*)
- o Oxazepam *(Serax)*
- o Temazepam (*Restoril*)

☐ **3. ANTI-PSYCHOTICS**
- o Aripiprazole (*Abilify*)
- o Chlorpromazine *(Thorazine)*
- o Clozapine (*Clozaril*)
- o Fluphenazine (*Permitil*)
- o Quetiapine (*Seroquel*)
- o Thioridazine (*Mellaril*)
- o Ziprasidone (*Geodon*)

☐ **4. ANTI-DEPRESSANTS / SSRI / SNRI / TCA**
- o Amitriptyline (*Vanatrip, Elavil)*
- o Bupropion (*Wellbutron*)
- o Citalopram (*Celexa*)
- o Desvenlafaxine (*Pristiq*)
- o Doxepin (*Silenor*, *Prudoxin*)
- o Duloxetine (*Cymbalta*)
- o Fluoxetine (*Prozac*)
- o Mirtazapine (*Remeron*)
- o Paroxetine (*Paxil*, *Pexeva*)
- o Sertraline (*Zoloft*)
- o Trazodone (*Oleptro*)
- o Venlafaxine (*Effexor XR*)

☐ **5. DEPRESSANTS**
- o Zolpidem (*Ambien*)
- o Zopiclone (*Zimovane*,*Lunesta)*

☐ **6. ANTI-CONVULSANTS**
- o Carbamazepine (*Tegretol*)
- o Gabapentin (*Neurontin*)
- o Lamotrigine (*Lamictal*)
- o Levetiracetam (*Keppra*)
- o Oxcarbazepine (*Trileptal*)
- o Pregabalin (*Lyrica*)
- o Tiagabine (*Gabitril*)
- o Zonisamide (*Zonegran*)

☐ **7. MUSCLE RELAXANTS**
- o Carisoprodol (*Soma*)
- o Cyclobenzaprine (*Flexeril*)

☐ **8. STIMULANTS**
- o Amphetamine (*Adderall*)
- o Caffeine (*Viviran, Cafcit*)
- o Methylphenidate (*Ritalin*)
- o Ritalinic Acid (*Methylphenidate*)

☐ **9. ANTIDOTES**
- o Naloxone (*Revia*, *Vivitrol*)

☐ **10. ILLICITS**
- o Methamphetamine (*Meth*)
- o Cocaine (*"Coke"*)
- o MDA (*Tenamfetamine*)
- o MDEA *("Eve")*
- o MDMA (*Ecstasy*, *Molly*)
- o Mephedrone (*Amphetamine*)
- o PCP (*Phencyclidine*)
- o THC (*Marijuana*)

SYNTHETIC CANNABINOIDS (K2/SPICE):
- o AM2201
- o HU-210
- o JWH-019
- o JWH-073-4-Hydroxybutyl
- o JWH-081
- o JWH-122
- o JWH-18-5-Pentonic Acid
- o JWH-18-5-Pentanyl
- o JWH-250-50H-Pentanyl

SAMPLE HANDLING

Time Collected: _____ AM/PM Date Collected: _____

Collected by: _____

The following ***MUST*** be completed (check all that apply):
- ☐ Desired Drug Panels marked above. **Separate Medication List provided.**
- ☐ Minimum of 5 mL specimen provided in **Urine Test** Cup ***or***
- ☐ Minimum of 0.25 mL specimen provided in **Oral Fluid** Device
- ☐ **Sample device sealed tightly**, bagged in BIOHAZARD BAG with no spill.

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: _____