



PRACTICE INFORMATION	MUST COMPLETE ALL FOLLOWING SECTIONS
Referring Physician: _____ _____ _____	<b>PATIENT INFORMATION</b> <hr/> Last Name _____ First Name _____ MI _____ <hr/> _____ / _____ / _____ Social Security: _____ - _____ - _____ <input type="checkbox"/> Male <input type="checkbox"/> Female Date of Birth <input type="checkbox"/> Self-Pay <input type="checkbox"/> Commercial Insurance <input type="checkbox"/> W/C: (Date of Injury): _____ <input type="checkbox"/> Medicare <hr/> <b>DIAGNOSTIC CODES (ICD-10):</b> _____

I certify that I have voluntarily provided a fresh unadulterated dried blood spot 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):**

<input type="checkbox"/> <b>TEST FOR ALL CLASSES BELOW (1-10):</b> <input type="checkbox"/> <b>1. NARCOTIC ANALGESICS / OPIATES</b> <input type="checkbox"/> Acetaminophen ( <i>Tylenol</i> ) <input type="checkbox"/> Buprenorphine ( <i>Butrans, Suboxone</i> ) <input type="checkbox"/> Codeine ( <i>Tylenol #3</i> ) <input type="checkbox"/> Fentanyl ( <i>Duragesics</i> ) <input type="checkbox"/> Hydrocodone ( <i>Norco, Vicodin</i> ) <input type="checkbox"/> Hydromorphone ( <i>Dilaudid</i> ) <input type="checkbox"/> Levorphanol ( <i>Levo-Dromoran</i> ) <input type="checkbox"/> Meperidine ( <i>Demerol</i> ) <input type="checkbox"/> Methadone ( <i>Methadose</i> ) <input type="checkbox"/> Morphine ( <i>MS Contin</i> ) <input type="checkbox"/> Tramadol ( <i>Ultram</i> ) <input type="checkbox"/> Oxycodone ( <i>Percocet, Oxycontin</i> ) <input type="checkbox"/> Oxymorphone ( <i>Opana</i> ) <input type="checkbox"/> Propoxyphene ( <i>Darvon</i> ) <input type="checkbox"/> Tapentadol ( <i>Nucynta</i> ) <input type="checkbox"/> <b>2. BENZODIAZEPINES</b> <input type="checkbox"/> Alprazolam ( <i>Xanax, Xanax XR</i> ) <input type="checkbox"/> Clonazepam ( <i>Klonopin</i> ) <input type="checkbox"/> Diazepam ( <i>Valium, Diastat</i> ) <input type="checkbox"/> Lorazepam ( <i>Ativan</i> ) <input type="checkbox"/> Oxazepam ( <i>Serax</i> ) <input type="checkbox"/> Temazepam ( <i>Restoril</i> ) <input type="checkbox"/> <b>3. ANTI-PSYCHOTICS</b> <input type="checkbox"/> Aripiprazole ( <i>Abilify</i> ) <input type="checkbox"/> Chlorpromazine ( <i>Thorazine</i> ) <input type="checkbox"/> Clozapine ( <i>Clozaril</i> ) <input type="checkbox"/> Fluphenazine ( <i>Permitil</i> ) <input type="checkbox"/> Quetiapine ( <i>Seroquel</i> )	<input type="checkbox"/> Thioridazine ( <i>Mellaril</i> ) <input type="checkbox"/> Ziprasidone ( <i>Geodon</i> ) <input type="checkbox"/> <b>4. ANTI-DEPRESSANTS / SSRI / SNRI / TCA</b> <input type="checkbox"/> Amitriptyline ( <i>Vanatrip, Elavil</i> ) <input type="checkbox"/> Bupropion ( <i>Wellbutrin</i> ) <input type="checkbox"/> Citalopram ( <i>Celexa</i> ) <input type="checkbox"/> Desvenlafaxine ( <i>Pristiq</i> ) <input type="checkbox"/> Doxepin ( <i>Silenor, Prudoxin</i> ) <input type="checkbox"/> Duloxetine ( <i>Cymbalta</i> ) <input type="checkbox"/> Fluoxetine ( <i>Prozac</i> ) <input type="checkbox"/> Mirtazapine ( <i>Remeron</i> ) <input type="checkbox"/> Paroxetine ( <i>Paxil, Pexeva</i> ) <input type="checkbox"/> Sertraline ( <i>Zoloft</i> ) <input type="checkbox"/> Trazodone ( <i>Olepto</i> ) <input type="checkbox"/> Venlafaxine ( <i>Effexor XR</i> ) <input type="checkbox"/> <b>5. DEPRESSANTS</b> <input type="checkbox"/> Zolpidem ( <i>Ambien</i> ) <input type="checkbox"/> Zopiclone ( <i>Zimovane, Lunesta</i> ) <input type="checkbox"/> <b>6. ANTI-CONVULSANTS</b> <input type="checkbox"/> Carbamazepine ( <i>Tegretol</i> ) <input type="checkbox"/> Gabapentin ( <i>Neurontin</i> ) <input type="checkbox"/> Lamotrigine ( <i>Lamictal</i> ) <input type="checkbox"/> Levetiracetam ( <i>Keppra</i> ) <input type="checkbox"/> Oxcarbazepine ( <i>Trileptal</i> ) <input type="checkbox"/> Pregabalin ( <i>Lyrica</i> ) <input type="checkbox"/> Tiagabine ( <i>Gabitril</i> ) <input type="checkbox"/> Zonisamide ( <i>Zonegran</i> )	<input type="checkbox"/> <b>7. MUSCLE RELAXANTS</b> <input type="checkbox"/> Carisoprodol ( <i>Soma</i> ) <input type="checkbox"/> Cyclobenzaprine ( <i>Flexeril</i> ) <input type="checkbox"/> <b>8. STIMULANTS</b> <input type="checkbox"/> Amphetamine ( <i>Adderall</i> ) <input type="checkbox"/> Caffeine ( <i>Viviran, Cafcit</i> ) <input type="checkbox"/> Methylphenidate ( <i>Ritalin</i> ) <input type="checkbox"/> Ritalinic Acid ( <i>Methylphenidate</i> ) <input type="checkbox"/> <b>9. ANTIDOTES</b> <input type="checkbox"/> Naloxone ( <i>Revia, Vivitrol</i> ) <input type="checkbox"/> <b>10. ILLICITS</b> <input type="checkbox"/> Methamphetamine ( <i>Meth</i> ) <input type="checkbox"/> Cocaine ("Coke") <input type="checkbox"/> MDA ( <i>Tenamfetamine</i> ) <input type="checkbox"/> MDEA ("Eve") <input type="checkbox"/> MDMA ( <i>Ecstasy, Molly</i> ) <input type="checkbox"/> Mephedrone ( <i>Amphetamine</i> ) <input type="checkbox"/> PCP ( <i>Phencyclidine</i> ) <input type="checkbox"/> THC ( <i>Marijuana</i> ) <b>SYNTHETIC CANNABINOIDS (K2/SPICE):</b> <input type="checkbox"/> AM2201 <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-250-50H-Pentanyl
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**SAMPLE HANDLING**

Time Collected: _____ AM/PM Date Collected: _____ Collected by: _____	The following <b>MUST</b> be completed (check all that apply): <input type="checkbox"/> Desired Drug Panels marked above. <b>Separate Medication List provided.</b> <input type="checkbox"/> <b>CleanAssure™</b> test by dried blood spot (use <b>4-tip Microsampling Kit</b> ). <input type="checkbox"/> <b>CleanAssure™</b> specimen must be shipped sealed in foil bag with desiccant.
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**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: \_\_\_\_\_