



PRACTICE INFORMATION	MUST COMPLETE ALL GREEN HIGHLIGHTED SELECTIONS
	PATIENT INFORMATION
Referring Physician: _____	Last Name _____ First Name _____ MI _____ _____/_____/_____ 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 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):

<input type="checkbox"/> TEST FOR ALL CLASSES BELOW (1-10): <input type="checkbox"/> URINALYSIS (VALIDITY) TESTING ONLY <input type="checkbox"/> 1. ANALGESICS / OPIATES <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"/> 2. BENZODIAZEPINES <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"/> 3. ANTI-PSYCHOTICS <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"/> 4. ANTI-DEPRESSANTS / SSRI / SNRI / TCA <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>Oleptro</i>) <input type="checkbox"/> Venlafaxine (<i>Effexor XR</i>) <input type="checkbox"/> 5. DEPRESSANTS <input type="checkbox"/> Zolpidem (<i>Ambien</i>) <input type="checkbox"/> Zopiclone (<i>Zimovane, Lunesta</i>) <input type="checkbox"/> 6. ANTI-CONVULSANTS <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"/> 7. MUSCLE RELAXANTS <input type="checkbox"/> Carisoprodol (<i>Soma</i>) <input type="checkbox"/> Cyclobenzaprine (<i>Flexeril</i>) <input type="checkbox"/> 8. STIMULANTS <input type="checkbox"/> Amphetamine (<i>Adderall</i>) <input type="checkbox"/> Caffeine (<i>Vivran, Cafcit</i>) <input type="checkbox"/> Methylphenidate (<i>Ritalin</i>) <input type="checkbox"/> Ritalinic Acid (<i>Methylphenidate</i>) <input type="checkbox"/> 9. ANTIDOTES <input type="checkbox"/> Naloxone (<i>Revia, Vivitrol</i>) <input type="checkbox"/> 10. ILLICITS <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>) SYNTHETIC CANNABINOIDS (K2/SPICE): <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 MUST be completed (check all that apply): <input type="checkbox"/> Desired Drug Panels marked above. Separate Medication List provided. <input type="checkbox"/> Minimum of 5 mL specimen provided in Urine Test Cup or <input type="checkbox"/> Minimum of 0.25 mL specimen provided in Oral Fluid Device <input type="checkbox"/> Sample device sealed tightly , bagged in BIOHAZARD BAG with no spill.
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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: _____