



PATIENT INFORMATION

PRACTICE INFORMATION

Last Name _____ First Name _____ MI _____ Facility/Group _____ Referring Physician _____
 _____ / _____ / _____ Social Security: _____ - _____ - _____ Male Female _____
 Date of Birth _____ Address _____ NPI Provider Nr. _____
 Address _____ **DIAGNOSTIC CODES (ICD-10 codes):** _____
 Self-Pay (attach Information) Commercial Insurance (attach copy) W/C (Date of Injury): _____ Medicare (attach copy of Insurance)

I certify that I have voluntarily provided a fresh unadulterated urine/dried blood/oral fluid specimen for analytical testing. The information provided on this form and on the label affixed to the specimen 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 (please check desired specimen type & drugs/drug classes for testing):

URINE SPECIMEN **DRIED BLOOD SPOT SPECIMEN (at least 3 tips required, recommend collecting all 4)** **ORAL FLUID SPECIMEN**

- URINALYSIS/VALIDITY TESTING (Urine)**
- TEST FOR ALL CLASSES BELOW (1-14)**
- 1. ANALGESICS / OPIATES**
 - Acetaminophen (*Tylenol*)
 - Buprenorphine (*Butrans*)
 - Butorphanol (*Stadol*)
 - Codeine (*Tylenol #3*)
 - Fentanyl (*Duragesic, Actiq*)
 - Hydrocodone (*Norco, Vicodin*)
 - Hydromorphone (*Dilaudid*)
 - Ketamine (*Ketalar*)
 - Levorphanol (*Levo-Dromoran*)
 - Meperidine (*Demerol*)
 - Methadone (*Methadose, Dolophine*)
 - Morphine (*MS Contin, Kadian, Duramorph, Avinza*)
 - Oxycodone (*Percocet, Oxycontin*)
 - Oxymorphone (*Opana*)
 - Propoxyphene (*Darvon*)
 - Tapentadol (*Nucynta*)
 - Tramadol (*Ultram*)
- 2. BENZODIAZEPINES**
 - Alprazolam (*Xanax, Niravam*)
 - Buspirone (*Buspar*)
 - Chlordiazepoxide (*Librium*)
 - Clobazam (*Onfi*)
 - Clonazepam (*Klonopin*)
 - Diazepam (*Valium, Diastat*)
 - Estazolam (*Prosom*)
 - Flunitrazepam (*Rohypnol*)
 - Flurazepam (*Dalmane*)
 - Lorazepam (*Ativan*)
 - Midazolam (*Versed*)
 - Oxazepam (*Serax*)
 - Prazepam (*Centrac*)
 - Temazepam (*Restoril*)
 - Triazolam (*Halcion*)
- 3. ANTI-PSYCHOTICS**
 - Aripiprazole (*Abilify*)
 - Chlorpromazine (*Thorazine*)
 - Clozapine (*Clozaril*)
 - Fluphenazine (*Permitil*)
 - Haloperidol (*Haldol*)
 - Olanzapine (*Zyprexa*)
 - Quetiapine (*Seroquel*)
 - Risperidone (*Risperdal*)
 - Thioridazine (*Mellaril*)
 - Ziprasidone (*Geodon*)
- 4. ANTI-DEPRESSANTS**
 - Amitriptyline (*Elavil*)
 - Bupropion (*Wellbutrin*)
 - Citalopram (*Celexa*)
 - Clomipramine (*Anafranil*)
 - Desipramine (*Norpramin*)
 - Desvenlafaxine (*Pristiq*)
 - Doxepin (*Silenor, Prudoxin*)
 - Duloxetine (*Cymbalta*)
 - Fluoxetine (*Prozac*)
 - Fluvoxamine (*Luvox*)
 - Imipramine (*Tofranil*)
 - D-L-Kavain, Yangelonin, Methysticin (*Kava*)
 - Mirtazapine (*Remeron*)
 - Nortriptyline (*Pamelor*)
 - Paroxetine (*Paxil, Pexeva*)
 - Sertraline (*Zoloft*)
 - Trazodone (*Oleptro*)
 - Venlafaxine (*Effexor*)
- 5. DEPRESSANTS**
 - Zaleplon (*Sonata*)
 - Zolpidem (*Ambien*)
 - Zopiclone (*Zimovane, Lunesta*)
- 6. ANTI-CONVULSANTS**
 - Carbamazepine (*Tegretol*)
- Gabapentin (*Neurontin*)
- Lamotrigine (*Lamictal*)
- Levetiracetam (*Keppra*)
- Oxcarbazepine (*Trileptal*)
- Pregabalin (*Lyrica*)
- Tiagabine (*Gabitril*)
- Valproic Acid (*Depakote*)
- Zonisamide (*Zonegran*)
- 7. MUSCLE RELAXANTS**
 - Baclofen (*Lioresal*)
 - Carisoprodol (*Soma*)
 - Cyclobenzaprine (*Flexeril*)
 - Methocarbamol (*Robaxin*)
- 8. STIMULANTS**
 - Amphetamine (*Adderall*)
 - Caffeine (*Vivarin, Cafcit*)
 - Ephedrine (*Bronkaid*)
 - Methylphenidate (*Ritalin*)
 - Lisdexamfetamine (*Vyvanse*)
 - Ritalinic Acid (*Methylphenidate*)
- 9. DECONGESTANTS**
 - Dextromethorphan (*Robitussin*)
 - Pseudoephedrine (*Sudafed*)
- 10. APPETITE STIMULANT**
 - Marinol (*Dronabinol Extract*)
 - Phentermine (*Suprenza*)
- 11. ANTIDOTES**
 - Naloxone (*Evizio*)
 - Naltrexone (*Revia, Vivitrol*)
- 12. ILLICITS**
 - 6-MAM (*Heroin*)
 - Acetyl-Fentanyl
 - Alpha-PVP (*"Flakka"*)
 - Carfentanil (*Wildnil®*)
 - Cocaine (*"Coke"*)
 - DMT (*Tryptamine*)
- MDA (*Tenamfetamine*)
- MDEA (*"Eve"*)
- MDMA (*Ecstasy, "Molly"*)
- MDPV (*Bath Salts*)
- Mephedrone (*Bath Salts*)
- Methamphetamine (*Meth*)
- Methylone (*Bath Salts*)
- Mitragynine (*Kratom*)
- PCP (*Phencyclidine*)
- THC (*Marijuana*)
- U-47700 (*Synthetic Opioid*)
- SPICE CANNABINOIDS**
 - 5-Fluoro NPB-22
 - AB-FUBINACA
 - AM-2201
 - FDU-PB-22
 - HU-210
 - JWH-019
 - JWH-073-4-Hydroxybutyl
 - JWH-081
 - JWH-122
 - JWH-18-5-Pentonic Acid
 - JWH-18-5-Pentanyl
 - JWH-250-5-OH-Pentanyl
 - MMB-CHMICA
- 13. BARBITURATES**
 - Amobarbital (*Amytal*)
 - Butobarbital (*Butisol*)
 - Butalbital (*Axotal*)
 - Phenobarbital (*Luminal*)
 - Pentobarbital (*Nembutal*)
 - Secobarbital (*Seconal*)
- 14. DIRECT BIOMARKERS**
 - Cotinine (*Nicotine*)
 - ETG (*Ethanol Metabolite*)
 - ETS (*Ethanol Metabolite*)

SAMPLE HANDLING The following **MUST** be completed (check all that apply):

Time Collected: _____ AM/PM Date Collected: _____
 Collected by: _____
 Desired Drug Panels marked above. **Separate Medication List provided.**
 Minimum of 5 mL specimen provided in **Urine Test Cup (seal lid!)**
 or Minimum of 0.25 mL specimen provided in **Oral Fluid Device**
 Urine/Saliva device sealed tightly & bagged in BIOHAZARD BAG with no spill
 or CleanAssure™ test by dried blood spot (**use 4-tip Microsampling Kit**).
 CleanAssure™ specimen must be shipped sealed in foil bag with desiccant.

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: _____