

CLARITY CLINICAL LABORATORY



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PLEASE PROVIDE COPY OF FRONT AND BACK OF INSURANCE CARD

TOXICOLOGY TEST REQUISITION

SPECIMEN INFORMATION

Date Collected _____ Time Collected _____ Collector's Name _____

Temperature read within 4 mins. and is range of 32.5-37.7°C (90.5-100°F)? YES NO

SPECIMEN TYPE URINE ORAL

CLIENT INFORMATION

PATIENT INFORMATION

Last Name _____ First Name _____

DOB (MM/DD/YY) _____ SSN _____ Sex M F

Phone (Day) _____ (Evening) _____

Insured's Address _____ Apt. _____ City _____ State _____ Zip _____

INSURANCE INFORMATION

Insured's Name (if different from Patient) _____

Primary Insurance Name & Plan _____

Address (Insurance) _____

Policy I.D. # _____ Group / Plan / Book # _____

A. PATIENT PRESCRIBED MEDICATIONS (Please check all that apply)

Including a medication in this section DOES NOT constitute a test request.

<input type="checkbox"/> alprazolam	<input type="checkbox"/> hydrocodone	<input type="checkbox"/> oxycodone	Other: _____
<input type="checkbox"/> amitriptyline	<input type="checkbox"/> hydromorphone	<input type="checkbox"/> paroxetine	
<input type="checkbox"/> amphetamine	<input type="checkbox"/> imipramine	<input type="checkbox"/> phenobarbital	
<input type="checkbox"/> buprenorphine	<input type="checkbox"/> ketamine	<input type="checkbox"/> phentermine	
<input type="checkbox"/> butabarbital	<input type="checkbox"/> lorazepam	<input type="checkbox"/> pregabalin	
<input type="checkbox"/> butalbital	<input type="checkbox"/> meperidine	<input type="checkbox"/> propoxyphene	
<input type="checkbox"/> carisoprodol	<input type="checkbox"/> meprobamate	<input type="checkbox"/> secobarbital	
<input type="checkbox"/> clonazepam	<input type="checkbox"/> methadone	<input type="checkbox"/> tapentadol	
<input type="checkbox"/> codeine	<input type="checkbox"/> methylphenidate	<input type="checkbox"/> temazepam	
<input type="checkbox"/> cyclobenzaprine	<input type="checkbox"/> morphine	<input type="checkbox"/> tramadol	
<input type="checkbox"/> desipramine	<input type="checkbox"/> naloxone	<input type="checkbox"/> venlafaxine	
<input type="checkbox"/> doxepin	<input type="checkbox"/> naltrexone	<input type="checkbox"/> zaleplon	
<input type="checkbox"/> duloxetine	<input type="checkbox"/> nordiazepam	<input type="checkbox"/> zolpidem	
<input type="checkbox"/> fentanyl	<input type="checkbox"/> normeperidine		
<input type="checkbox"/> fluoxetine	<input type="checkbox"/> oxazepam		
<input type="checkbox"/> gabapentin	<input type="checkbox"/> oxycodone		

An inconsistent result may be reflected on the report if a complete list of patient's prescribed medications is not provided.

C. NON POC TESTING OPTIONS

Presumptive Immunoassay drug screen

Confirm all positives and prescribed medications

Perform Specimen Validity

Order confirmation testing on all drugs listed below

D. REQUEST ADDITIONAL DRUG CONFIRMATION BY DRUG CLASS

<input type="checkbox"/> Amphetamines	<input type="checkbox"/> Benzodiazepines	<input type="checkbox"/> Non Opioid: Analgesics
<input type="checkbox"/> Anti-Convulsants	<input type="checkbox"/> Illicits	<input type="checkbox"/> Opioids/ Opiates
<input type="checkbox"/> Anti-Depressants	<input type="checkbox"/> Muscle Relaxants	<input type="checkbox"/> Synthetic Cannabinoids
<input type="checkbox"/> Barbiturates	<input type="checkbox"/> Non Benzodiazepine Hypnotic	

E. ORDER INDIVIDUAL CONFIRMATION TESTS

AMPHETAMINES <input type="checkbox"/> Amphetamine <input type="checkbox"/> Methamphetamine <input type="checkbox"/> Ritalinic Acid ANTI-CONVULSANTS <input type="checkbox"/> Gabapentin <input type="checkbox"/> Pregabalin ANTI-DEPRESSANTS <input type="checkbox"/> Amitriptyline <input type="checkbox"/> Desipramine <input type="checkbox"/> Doxepin <input type="checkbox"/> Duloxetine <input type="checkbox"/> Fluoxetine <input type="checkbox"/> Imipramine <input type="checkbox"/> Nortriptyline <input type="checkbox"/> Paroxetine <input type="checkbox"/> Venlafaxine	<input type="checkbox"/> Sertraline <input type="checkbox"/> Quetiapine (Seroquel) <input type="checkbox"/> Trazodone BARBITURATES <input type="checkbox"/> Butabarbital <input type="checkbox"/> Butalbital <input type="checkbox"/> Phenobarbital <input type="checkbox"/> Secobarbital BENZODIAZEPINES <input type="checkbox"/> Alprazolam <input type="checkbox"/> Alpha-hydroxyalprazolam <input type="checkbox"/> 7-Aminoclonazepam <input type="checkbox"/> Lorazepam <input type="checkbox"/> Nordiazepam <input type="checkbox"/> Oxazepam <input type="checkbox"/> Temazepam <input type="checkbox"/> Clonazepam	<input type="checkbox"/> Diazepam <input type="checkbox"/> Flunitrazepam <input type="checkbox"/> Midazolam <input type="checkbox"/> Nordiazepam <input type="checkbox"/> Triazolam ILLICITS <input type="checkbox"/> 6- MAM (Heroin Metabolite) <input type="checkbox"/> Benzoyllecgonine (Cocaine) <input type="checkbox"/> Ketamine <input type="checkbox"/> MDA <input type="checkbox"/> MDEA <input type="checkbox"/> MDMA (Ecstasy) <input type="checkbox"/> Phencyclidine (PCP) <input type="checkbox"/> Mitragynine (Kratom) <input type="checkbox"/> Norketamine MUSCLE RELAXANTS <input type="checkbox"/> Carisoprodol	<input type="checkbox"/> Cyclobenzaprine <input type="checkbox"/> Meprobamate NON BENZODIAZEPINE HYPNOTIC <input type="checkbox"/> Zaleplon <input type="checkbox"/> Zolpidem <input type="checkbox"/> Carboxy zolpidem NON OPIOID ANALGESICS <input type="checkbox"/> 0-Desmethyltramadol <input type="checkbox"/> Tapentadol <input type="checkbox"/> Tramadol OPIOIDS/OPIATES <input type="checkbox"/> Codeine <input type="checkbox"/> Morphine <input type="checkbox"/> Buprenorphine <input type="checkbox"/> Norbuprenorphine <input type="checkbox"/> Hydrocodone	<input type="checkbox"/> Hydromorphone <input type="checkbox"/> Oxycodone <input type="checkbox"/> Oxycodone <input type="checkbox"/> Fentanyl <input type="checkbox"/> Norfentanyl <input type="checkbox"/> Meperidine (Demerol) <input type="checkbox"/> Normeperidine <input type="checkbox"/> (Nordemerol) <input type="checkbox"/> Methadone <input type="checkbox"/> EDDP <input type="checkbox"/> Naloxone <input type="checkbox"/> Naltrexone <input type="checkbox"/> Propoxyphene <input type="checkbox"/> Dihydrocodeine <input type="checkbox"/> Norhydrocodone <input type="checkbox"/> Norpropoxyphene <input type="checkbox"/> Sufentanil	<input type="checkbox"/> Noroxycodone <input type="checkbox"/> Desomorphine SYNTHETIC CANNABINOIDS <input type="checkbox"/> JWH-018 Pentanoic Acid <input type="checkbox"/> UR-1445 OTHER TESTS <input type="checkbox"/> THC-COOH <input type="checkbox"/> Phentermine <input type="checkbox"/> Dextromethorphan <input type="checkbox"/> Dextrorphan <input type="checkbox"/> Cotinine (Nicotine) <input type="checkbox"/> SPECIMEN VALIDITY <input type="checkbox"/> Creatinine <input type="checkbox"/> PH <input type="checkbox"/> Specific Gravity
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PATIENT AUTHORIZATION

I certify that I have voluntarily provided a fresh and unadulterated urine specimen for analytical testing. The information provided on this form and on the label affixed to the specimen cup is accurate. I authorize Clarity Clinical Laboratory, LLC (CCL) to release the result of this testing to the authorized treating healthcare provider or facility. I hereby authorize my insurance benefits to be paid directly to CCL for services I have received. I acknowledge that CCL may be an out-of-network provider with my insurer. I am also aware that in some circumstances my insurer will send the payment directly to me. I agree to endorse the insurance check and forward it to CCL within 30 days of receipt. Failure to do so may result in my account being forwarded to a collection agency and reported to a credit bureau. I understand that CCL may use my specimen and any testing performed on that specimen for research, development, and potential publication purposes, as long as the information has been properly de-identified pursuant to the law.

Patient Signature: _____ Date: _____

Please select the most appropriate ICD-10 code(s). The codes listed below are not an exhaustive list, but are only a sample of commonly used codes. If the most appropriate code is not listed below, please write in the most appropriate ICD-10 code(s) in the blank.

DIAGNOSIS CODE	DESCRIPTION
F19.20	Psychoactive substance dependence uncomplicated
F19.21	Psychoactive substance dependence in remission
F19.229	Other psychoactive substance dependence with intoxication unspecified
F19.230 - F19.232	Other psychoactive substance dependence with withdrawal
F33.0	Major depressive order, recurrent, mild
F41.9	Anxiety disorder
F90.9	Hyperactivity
G47.9	Sleep disorder, unspecified
G89.4	Chronic Pain Syndrome
M51.14	Intervertebral disc disorders with radiculopathy, thoracic region
M51.15	Intervertebral disc disorders with radiculopathy, thoracolumbar region
M51.16	Intervertebral disc disorders with radiculopathy,lumbar region
M51.17	Intervertebral disc disorders with radiculopathy, lumbosacral region
M51.36	Other intervertebral disc degeneration, lumbar region
M51.37	Other intervertebral disc degeneration, lumbosacral region
M54.14	Radiculopathy, thoracic region
M54.15	Radiculopathy, thoracolumbar region
M54.16	Radiculopathy, lumbar region
M54.17	Radiculopathy, lumbosacral region
M54.18	Radiculopathy, sacral and sacrococcygeal region
M54.5	Low back pain
M79.1	Myalgia unspecified
Z03.89	Encounter for observation for other suspected conditions ruled out
Z51.81	Encounter for therapeutic drug level
Z79.1	Long term use of non-steroidal anti-inflammatories (NSAID)
Z79.82	Long term (current) use of aspirin
Z79.83	Long term (current) use of biphosphonates
Z79.891	Long term (current) use of opiate analgesic
Z79.899	Long term use of drug therapy