

DRUG TEST RECORD FORM

Specimen ID Number: _____ Date of Collection _____

Collection Site / Company Information: (Information about the company doing the testing)

Company _____
 Address _____ Suite: _____
 City _____ State: _____ Zip: _____
 Collector's Name _____ Phone: _____
 Specimen Temperature: (92-100 F.) In Range? Yes No Fax: _____

Donor Information: (Information about the person being tested)

Donor's Name _____
 Photo ID# or SSN _____
 Identification Type _____
 Notes _____
 Day Time Phone: _____ Evening Phone: _____

Drug testing kit information

Lot Number: _____
 Expiration Date: _____
 Panel type: 4 5 6 8
 10 11 12

Certification Information: (must be signed by collector and donor)

I hereby certify that the specimen provided is my own and has not been substituted or adulterated. I further agree and grant permission for the testing of my specimen for drug metabolites and/or alcohol.

Donor's Signature

Date _____

I hereby certify that I collected the specimen provided by the aforementioned Donor and that it was not substituted or adulterated to the best of my knowledge. The specimen temperature and color were acceptable.

Collector's Signature

Date _____

Initial Screen Results: (All "Confirm" or non-negative results must be confirmed using GC/MS*)

| Drug Name | Device Code | Negative | Non Negative | Not Tested | Adulteration Panel Results <small>(See color chart and package insert for interpretation)</small> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Cocaine | COC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; text-align: center;"><input type="checkbox"/></td> <td style="width: 50px;">Oxidant</td> <td>Normal <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td>Abnormal <input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td>Other _____</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>Specific Gravity</td> <td>Normal <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td>Abnormal <input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td>Other _____</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>pH</td> <td>Normal <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td>Abnormal <input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td>Other _____</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>Nitrite</td> <td>Normal <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td>Abnormal <input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td>Other _____</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>GL</td> <td>Normal <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td>Abnormal <input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td>Other _____</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td>Creatinine</td> <td>Normal <input type="checkbox"/></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td>Abnormal <input type="checkbox"/></td> </tr> <tr> <td></td> <td></td> <td>Other _____</td> </tr> </table> | <input type="checkbox"/> | Oxidant | Normal <input type="checkbox"/> | <input type="checkbox"/> | | Abnormal <input type="checkbox"/> | | | Other _____ | <input type="checkbox"/> | Specific Gravity | Normal <input type="checkbox"/> | <input type="checkbox"/> | | Abnormal <input type="checkbox"/> | | | Other _____ | <input type="checkbox"/> | pH | Normal <input type="checkbox"/> | <input type="checkbox"/> | | Abnormal <input type="checkbox"/> | | | Other _____ | <input type="checkbox"/> | Nitrite | Normal <input type="checkbox"/> | <input type="checkbox"/> | | Abnormal <input type="checkbox"/> | | | Other _____ | <input type="checkbox"/> | GL | Normal <input type="checkbox"/> | <input type="checkbox"/> | | Abnormal <input type="checkbox"/> | | | Other _____ | <input type="checkbox"/> | Creatinine | Normal <input type="checkbox"/> | <input type="checkbox"/> | | Abnormal <input type="checkbox"/> | | | Other _____ |
| <input type="checkbox"/> | Oxidant | Normal <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | | Abnormal <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <input type="checkbox"/> | Specific Gravity | Normal <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <input type="checkbox"/> | Nitrite | Normal <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| <input type="checkbox"/> | GL | Normal <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| | | Other _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | Creatinine | Normal <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="checkbox"/> | | Abnormal <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | Other _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Marijuana | THC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Opiates/Morphine | OPI/MOR | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Amphetamines | AMP | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Methamphetamine | mAMP | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Phencyclidine | PCP | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Benzodiazepine | BZO | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Barbiturates | BAR | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Methadone | MTD | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tricyclic Antidepressants | TCA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Oxycodone | OXY | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Propoxyphene | PPX | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Methylenedioxyamphetamine | MDMA (Ecstasy) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Buprenorphine | BUP | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ALCOHOL SCREEN | ALC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |