TOPLAB

TL10000

67-71 East Willow Street
Millburn, NJ 07041
Phone: 877-355-3580

1 PRACTICE INFORMATION

Healthcare Providor Signature Date Ordered

Diagnosis code(s)

SPECIMEN DATA

Date Collected: ____/____/____ Time: ____ : ____ AM PM

Collector: ____ Temp ____

FASTING ☐ YES ☐ NO

STAT

ORDERING PHYSICIANS

2 PATIENT INFORMATION

Last Name ____ First Name ____

Middle Name ____ ☐F ☐M DOB ____/____/____ Phone: (____) ____

Address ____ SSN: ___-___-____

City: ____ State: ____ Zip: ____ Pt. ID ____

Insurance Company ____

Claim Number ____ Date of Accident ____

Billing Information

☐ Patient ☐ Medicare ☐ Insurance ☐ Auto Injury
☐ Client ☐ Medicaid ☐ Workers Comp.

Relationship

☐ Self ☐ Spouse ☐ Child
☐ Other ____

3 POINT-OF-CARE TEST/ ORDER CONFIRMATION TESTS

	DRUG	POS(+)	NEG(-)		DRUG	POS(+)	NEG(-)		DRUG	POS(+)	NEG(-)
BENZO	BENZO	☐	☐	ILL	MET	☐	☐	ILL	PCP	☐	☐
BARB	BARB	☐	☐	OPIA	OPI	☐	☐	STIM	AMP	☐	☐
ILL	COC	☐	☐	OPIS	MTD	☐	☐	PPX	PPX	☐	☐
CANB	THC	☐	☐	OPIA	OXY	☐	☐	OPIS	BUP	☐	☐

4 PERFORM DEFINITIVE TEST FOR SPECIFIC DRUG

☐ Full Tox Panel ☐ Oral Fluid Panel* Only applies to tests marked with (*)

☐ Specimen Validity Testing (pH,Specific Gravity, Creatine) ☐ Screen All ☐ Screen w/ Reflex Confirmation

☐ ANALGESICS (ANA)
- ☐ Acetaminophen

☐ ANTICONVULSANTS (ANT)
- ☐ Gabapentin*
- ☐ Pregabalin*

☐ ANTIDEPRESSANTS (ANTD)
- ☐ Amitriptyline*
- ☐ Duloxetine
- ☐ Norfluoxetine
- ☐ Nortriptyline*
- ☐ Paroxetine
- ☐ Velafaxine

☐ BENZODIAZEPINES (BEN)
- ☐ Alpha-Hydroxyalprazolam*
- ☐ Alpha-Hydroxymidazolam
- ☐ Alpha-Hydroxytriazolam
- ☐ Alprazolam*
- ☐ 7-Aminoclonazepam*
- ☐ 7-Aminoflunitrazepam
- ☐ Clonazepam*
- ☐ N-Desmethylflunitrazepam
- ☐ Diazepam*
- ☐ Flurazepam*
- ☐ Flunitrazepam*
- ☐ 2-Hydroxyethylflurazepam
- ☐ Lorazepam*
- ☐ Midozolam*
- ☐ Oxazepam*
- ☐ Temazepam*

☐ CANNABINOID (CANB)
- ☐ THC*

☐ ILLICITS (ILL)
- ☐ 6 MAM (Heroin Metabolite)*
- ☐ Acetyl Fentanyl
- ☐ Benzoylecgonine (Cocaine)*
- ☐ Ketamine
- ☐ MDA*
- ☐ MDEA*
- ☐ MDMA (Ecstacy)*
- ☐ Methamphetamine*
- ☐ Phencyclidine (PCP)

☐ ILLICITS: SYNTHETICS (ILLS)
- ☐ Spices (Syn. THC)

☐ MUSCLE RELAXANTS (MUS)
- ☐ Carisprodol
- ☐ Cyclobenzaprine
- ☐ Meprobamate*

☐ OPIATES/OPIOIDS (OPIA)
- ☐ Codeine*
- ☐ Hydrocodone*
- ☐ Hydromorphone*
- ☐ Morphine*
- ☐ Noroxycodone*
- ☐ Oxycodone*
- ☐ Oxymorphone*

☐ OPIOIDS: SYNTHETIC (OPIS)
- ☐ 6-Beta-Naltrexol
- ☐ Buprenorphine*
- ☐ Fentanyl*
- ☐ Meperidine*
- ☐ Methadone/EDDP*
- ☐ Mitragynine
- ☐ Naloxone (Suboxone)*
- ☐ Naltrexone (Vivitrol)*
- ☐ N-Desmethyltapentadol
- ☐ Norbuprenorphine*
- ☐ Norfentanyl Oxalate*
- ☐ Normerperidine
- ☐ O-Desmethyl-Cis-Tramadol*
- ☐ Tramadol*
- ☐ Tapentadol*

☐ SEDATIVE HYPNOTICS (SED)
- ☐ Zaleplon
- ☐ Zolpidem

☐ STIMULANTS (STIM)
- ☐ Amphetamine*
- ☐ Butylone
- ☐ Ethylone
- ☐ MDPV*
- ☐ Mephedrone
- ☐ Methylone
- ☐ Methylphenidate
- ☐ Naphyrone

5 PSYCHIATRIC PANEL (PSYCH)

☐ Antipsychotics (AP)
- ☐ 9-Hydroxyriseridone
- ☐ Aripiprazole
- ☐ Clonidine
- ☐ Norquetiapine
- ☐ Quetiapine
- ☐ Risperidone

☐ Antidepressants (AD)
- ☐ Citalopram
- ☐ Duloxetine
- ☐ Fluoxetine
- ☐ Norfluoxetine
- ☐ Paroxtine
- ☐ Sertaline
- ☐ Venlafaxine

6 PRESCRIBED MEDICATIONS

BRAND NAME (CHEMICAL NAME)
- ☐ Xanex (Alprozolam)
- ☐ Elavil (Amitriptyline)
- ☐ Adderall (Amphetamine)
- ☐ Subutex (Buprenorphine)
- ☐ Suboxone (Buprenorphine)
- ☐ Wellbutrin (Bupropion)
- ☐ Klonopin (Clonazepam)
- ☐ Tylenol 3 (Codeine)
- ☐ Flexeril (Cyclobenzaprine)
- ☐ Valium (Diazepam)
- ☐ Duragesic (Fentanyl)
- ☐ Neurontin (Gabapentin)
- ☐ Lortab, Vicodin (Hydrocodone)
- ☐ Dilaudid (Hydromorphone)
- ☐ Dolophine (Methadone)
- ☐ Ritalin (Methylphenidate)
- ☐ Avinza (Morphine)
- ☐ Revia (Naltrexone)
- ☐ Percocet (Oxycodone)
- ☐ Opana (Oxymorphone)
- ☐ Lyrica (Pregabalin)
- ☐ Medical Marijuana (THC)
- ☐ Ultram (Tramadol)

OTHER
- ☐ ____
- ☐ ____
- ☐ ____
- ☐ ____
- ☐ ____

7 PATIENT AUTHORIZATION

I certify that I have voluntarily provided a fresh and unadulterated urine specimen for analytical testing. The information on this form and on the label affixed to the specimen cup is accurate. I authorize Toplab to release the results of this testing to the treating authorized healthcare provider or facility. I hereby authorize my insurance plan to be billed and benefits to be paid directly to Toplab for services I received. I acknowledge that Toplab 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 insurance check and forward it to Toplab within 30 days of receipt. Failure to do so may result in my account being forwarded to Collections and reported to a Credit Bureau. I understand that Toplab may use my specimen and any testing performed on that specimen, for research, development and potential publication purposes, so long as the information has been properly de-identified pursuant to law.

Patient Signature Date

Pt Name ____ Date____/____/____

Donor Intials____ Date of Birth____/____/____

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