Patient Name DOB

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CLIA #05D0567262

Customer Information

REQUISITION FOR DEFINITIVE DRUG TESTING USING LC-MS/MS

Last Name: ______________________ DOB: _____ / _____ / _____

First Name: ______________________ Biological Sex: ☐ M ☐ F

Date Collected: _____ / _____ / _____ ☐ Attach patient demographic with insurance card ☐ Uninsured Patient

Diagnosis Code(s): ______________ Ordering Provider: ______________

PLEASE SELECT GROUP(S) OR SINGLE DRUG(S)

Opiates/Opioids ☐	**Benzodiazepines** ☐	**Illicit Drugs** ☐	**Other Drugs** ☐	**Special Opioids** ☐
Tylenol 3 (Codeine) ☐	Xanax (Alprazolam) ☐	Methamphetamine ☐	Adderall (Amphetamine) ☐	Suboxone (Buprenorphine) ☐
Norco (Hydrocodone) ☐	Klonopin (Clonazepam) ☐	Cocaine ☐	Ritalin (Methylphenidate) ☐	Naloxone ☐
Dilaudid (Hydromorphone) ☐	Valium (Diazepam) ☐	MDMA ☐	Marijuana (THC)+ ☐	Methadose (Methadone) ☐
MS Contin (Morphine) ☐	Serax (Oxazepam) ☐	Heroin (6-MAM) ☐	Ethyl Glucuronide+ ☐	Duragesic (Fentanyl) ☐
Percocet (Oxycodone) ☐	Restoril (Temazepam) ☐	PCP ☐	Barbiturates* ☐	Nucynta (Tapentadol) ☐
Opana (Oxymorphone) ☐	Ativan (Lorazepam) ☐	Bath Salts (Cathinones) ☐	Kratom (Mitragynine) ☐	Ultram (Tramadol) ☐
		Neuropathics ☐	Ambien (Zolpidem) ☐	Demerol (Meperidine) ☐
		Neurontin (Gabapentin) ☐	**Muscle Relaxants** ☐	**Antidepressants** ☐
		Lyrica (Pregabalin) ☐	Soma (Carisoprodol) ☐	Elavil (Amitriptyline) ☐
			Flexeril (Cyclobenzaprine) ☐	Paxil (Paroxetine) ☐
			Equanil (Meprobamate) ☐	Norpramin (Desipramine) ☐
				Tofranil (Imipramine) ☐

**Qualitative only*
+Semi-quantitative immunoassay

☐ Medication List Attached *(Birdrock Laboratories will only enter medications that have been prescribed or refilled within the last 90 days)*

Prescribed Medications

AUTHORIZATION/SIGNATURES

DONOR: I certify that the specimen and information provided is my own and has not been substituted or adulterated. I further grant permission for the testing of my specimen for the presence of drugs and/or alcohol. I authorize Birdrock Laboratories to share the information on this form and my test results with my designated insurance carrier if necessary for reimbursement, to appeal any reimbursement denial, and authorize all reimbursements to be paid directly to the laboratory in consideration of services performed. I acknowledge that Birdrock Laboratories may be outside my network of insurance and I may be responsible for the amount due as determined by said insurance. I authorize Birdrock Laboratories to release the results of this testing to the treating authorized healthcare provider or facility.

ORDERING PROVIDER: I certify that the above ordered tests are medically necessary for the diagnosis and treatment of this patient. I have documented this test in the patient's chart.

Donor Authorization Signature:	Date:	Ordering Health Care Provider Signature *(Required)*:	Date *(Required)*:

SAMPLE