502750

Patient Name DOB

502750

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Lab Director: Amadeo Pesce, Ph.D.
CLIA #05D0567262

Customer Information

REQUISITION FOR DEFINITIVE DRUG TESTING VIA LC/MS

Last Name: ______________________ First Name: ______________________ DOB: _____ / _____ / _____
(Must be 18 years or older)

Date Collected: _____ / _____ / _____ Time Collected: _____ : _____ AM / PM Biological Sex: ☐ M ☐ F

Ordering Provider: ______________________ ☐ Attach patient demographics w/insurance card ☐ Uninsured Patient

Diagnosis Code(s):* __________ __________ __________ __________ __________

☐ Black/African-American ☐ Hispanic/Latino/Spanish Origin ☐ Asian ☐ American Indian/Alaskan Native
☐ White/Caucasian ☐ Native Hawaiian/Other Pacific Islander ☐ Other: __________ ☐ Refused

* Documentation in the patient's medical record must support the medical necessity for ordering the service(s) per Medicare regulations and applicable Local Coverage Determinations (LCDs)

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: Medicare will only pay for tests that meet the Medicare coverage criteria and are reasonable and necessary to treat or diagnose an individual patient. Section 1862(a)(1)(A) of the Social Security Act states, "no payment may be made under Part A or Part B for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." Tests submitted for Medicare reimbursement must meet program requirements or the claim may be denied. 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. I acknowledge that Medicare does not generally cover routine screening tests.

The patient understands and agrees that the patient's leftover specimen and clinical information may be used, without information directly identifying the patient, for research, education, and other business purposes of Birdrock Laboratories (each a "secondary use" and together "secondary uses"). The patient understands that this may involve Birdrock Laboratories sharing the patient's leftover specimen and clinical information with other third parties. The patient's leftover specimen and clinical information will be assigned a unique code before any secondary uses. The patient's name or other personal identifying information will not be used in or linked to the patient's specimen and clinical information when they are shared with third parties unless the patient explicitly authorizes that disclosure. Furthermore the leftover specimen will become the property of Birdrock Laboratories. The specimens could lead to discoveries or inventions that may be of value to Birdrock Laboratories or to other organizations. You do not have any right to money or other compensation stemming from products that may be developed from the specimens unless expressly required under applicable state law.

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

SAMPLE