Identify® Health

Why Identify? Because you need to know.

DRUG TEST RESULT FORM

SPECIMEN ID:

TEST DATE:

DONOR INFORMATION (PATIENT BEING SCREENED)

LAST NAME: _____ **FIRST:** _____

DOB: _____

EMPLOYEE ID

COMPANY INFORMATION (COMPANY PERFORMING TEST)

COMPANY:

ADDRESS:

CITY: **STATE:** **ZIP:**

CERTIFICATION

I certify 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.

DONOR SIGNATURE: _____ **DATE:** _____

I certify I collected the specimen provided by the aforementioned donor and that it is not substituted or adulterated to the best of my knowledge. Specimen temperature & color were acceptable.

COLLECTOR SIGNATURE: _____ **DATE:** _____

DEVICE NAME: _____

EXPIRATION: _____

TEMPERATURE BETWEEN 90°-100°

YES ☐ **NO** ☐

ITEM #: _____ **LOT #:** _____ **NOTES:** _____

DRUG NAME	CUT-OFF	NEGATIVE	POSITIVE	NOT TESTED
Cotinine (COT)	200 ng/mL			

LOW	NORMAL	HIGH	LOW	NORMAL	HIGH	LOW	NORMAL	HIGH	LOW	NORMAL	HIGH	LOW	NORMAL	HIGH	LOW	NORMAL	HIGH