



DRUG TEST RESULT FORM SPECIMEN ID: TEST DATE:

DONOR INFORMATION (PATIENT BEING SCREENED)				
LAST NAME:		FIRST:		EMPLOYEE ID
DOB:				
COMPANY INFORMATION (COM		IING TEST)		
COMPANY:		,		
ADDRESS:				
CITY:	STATE:	ZIP:		
CERTIFICATION				
I certify the specimen provided is r	ny own and has	not been substit	uted or adulter	ated. I further
agree and grant permission for the	•			
DONOR SIGNATURE: DATE:				
I certify I collected the specimen p				
or adulterated to the best of my kn	•			
COLLECTOR SIGNATURE: DATE:				
DEVICE NAME: TEMPERATURE BETWEEN 90°-100°				
EXPIRATION:YES \(\text{NO} \(\text{D} \)				
ITEM #:				
DRUG NAME	CUT-OFF	NEGATIVE		NOT TESTED
Amphetamines (AMP)	1,000 ng/mL			
Barbiturates (BAR)	300 ng/mL			
Benzodiazepines (BZO)	300 ng/mL			
Cocaine (COC)	300 ng/mL			
Marijuana (THC)	50 ng/mL			
Methadone (MTD)	300 ng/mL			
Methamphetamines (MET)	1,000 ng/mL			
Opiates / Morphine (OPI/MOP)	300 ng/mL			
Oxycodone (OXY)	100 ng/mL			
Phencyclidine (PCP)	25 ng/mL			
LOW NORMAL HIGH LOW NORMAL HIGH	LOW NORMAL HIGH	LOW NORMAL HIGH	LOW NORMAL F	HIGH LOW NORMAL HIGH