



DRUG TEST RESULT FORM

SPECIMEN ID:

TEST DATE:

DONOR INFORMATION (PATIENT BEING SCREENED)

LAST NAME: _____ **FIRST:** _____

EMPLOYEE ID

DOB: _____

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: _____ **TEMPERATURE BETWEEN 90°-100°**

EXPIRATION: _____ **YES** ☐ **NO** ☐

ITEM #: _____ LOT #: _____ NOTES: _____

DRUG NAME	CUT-OFF	NEGATIVE	POSITIVE	NOT TESTED
Amphetamines (AMP)	500 ng/mL			
Barbiturates (BAR)	300 ng/mL			
Benzodiazepines (BZO)	300 ng/mL			
Buprenorphine (BUP)	10 ng/mL			
Cocaine (COC)	150 ng/mL			
Ecstasy (MDMA)	500 ng/mL			
Fentanyl (FYL)	1 ng/mL			
Marijuana (THC)	50 ng/mL			
Methadone (MTD)	300 ng/mL			
Methamphetamines (MET)	500 ng/mL			
Morphine / Opiates (MOP)	300 ng/mL			
Oxycodone (OXY)	100 ng/mL			

[illegible]