

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			
Marijuana (THC)	50 ng/mL			
Methadone (MTD)	300 ng/mL			
Methadone Metabolite (EDDP)	300 ng/mL			
Methamphetamines (MET)	500 ng/mL			
Opiates / Morphine (OPI300)	300 ng/mL			
Oxycodone (OXY)	100 ng/mL			
Phencyclidine (PCP)	25 ng/mL			
Tricyclic Antidepressants (TCA)	1000 ng/mL			

Specific Gravity (SG)	(PH)	Creatinine (CRE)	Glutaraldehyde (GL)	Nitrite (NI)	Oxidants (OX)
LOW NORMAL HIGH	LOW NORMAL HIGH	LOW NORMAL HIGH	LOW NORMAL HIGH	LOW NORMAL HIGH	LOW NORMAL HIGH