



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 #: LO	LOT #: NOTES:			
DRUG NAME	CUT-OFF	NEGATIVE	POSITIVE	NOT TESTED
Amphetamines (AMP)	500 ng/mL			
Benzodiazepines (BZO)	300 ng/mL			
Buprenorphine (BUP)	10 ng/mL			
Cocaine (COC)	150 ng/mL			
Ecstasy (MDMA)	500 ng/mL			
Ethyl Glucuronide (ETG)	500 ng/mL			
Fentanyl (FEN)	20 ng/mL			
Marijuana (THC)	50 ng/mL			
Methadone (MTD)	300 ng/mL			
Methamphetamines (MET)	500 ng/mL			
Opiates / Morphine (OPI300)	300 ng/mL			
Oxycodone (OXY)	100 ng/mL			
Synthetic Marijuana (K2)	25 ng/mL			
Tramadol (TRA)	100 ng/mL			
Creatinine (CRE) Oxidants (OX)	(PH)	LOW NORMAL HIGH	LOW NORMAL H	IGH LOW NORMAL HIGH