



DRUG TEST RESULT FORM SPECIMEN ID: TEST DATE:

DONOR INFORMATION (PATIENT BEING SCREENED)					
_AST NAME:		FIRST:			EMPLOYEE ID
DOB:					
COMPANY INFORMATION (COMPANY PERFORMING TEST)					
COMPANY:					
ADDRESS:					
CITY:			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 \(\square\) NO \(\square\)					
ITEM #: LOT #: NOTES:					
DRUG NAME		CUT-OFF	NEGATIVE	POSITIVE	NOT TESTED
Amphetamines	(AMP)	1,000 ng/mL			
Cocaine (COC)		300 ng/mL			
Marijuana (THC)		50 ng/mL			
Methamphetamines (MET)		1,000 ng/mL			
Morphine / Opiates (MOP/OPI)		300 ng/mL			
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LOW NORMAL HIGH	LOW NORMAL HIGH	LOW NORMAL HIGH	LOW NORMAL HIGH	LOW NORMAL H	GH LOW NORMAL HIGH