TOPLAB

67-71 East Willow Street
Millburn, NJ 07041
Phone: 877-355-3580

1 PRACTICE INFORMATION

Healthcare Providor Signature

Date Ordered

Diagnosis code(s)

SPECIMEN DATA

Date Collected: ____ / ____ / ____ Time: ____ : ____ AM PM

Collector: ____ Temp ____

FASTING YES NO

STAT

ORDERING PHYSICIANS

2 PATIENT INFORMATION

Last Name ____ First Name ____

Middle Name ____ ☐F ☐M DOB ____ / ____ / ____ Phone: (____) ____

Address ____ SSN: ___ - ___ - ____

City: ____ State: ____ Zip: ____ Pt. ID ____

Insurance Company ____

Claim Number ____ Date of Accident ____

Billing Information

☐ Patient ☐ Medicare ☐ Insurance ☐ Auto Injury
☐ Client ☐ Medicaid ☐ Workers Comp.

Relationship

☐ Self ☐ Spouse ☐ Child
☐ Other ____

3 PATIENT PRESCRIBED MEDICATIONS

	Last Use
____	____ / ____ / ____
____	____ / ____ / ____
____	____ / ____ / ____
____	____ / ____ / ____

4 POINT-OF-CARE TEST/ ORDER CONFIRMATION TESTS

	MEDICATION OR DRUG	CONF. POS(+)	CONF. NEG(-)		MEDICATION OR DRUG	CONF. POS(+)	CONF. NEG(-)
1131	BZO BENZODIAZEPINE	☐	☐	1132	MTD METHADONE	☐	☐
1134	BAR BARBITURATES	☐	☐	1137	OXY OXYCODONE	☐	☐
486	COC COCAINE	☐	☐	486	PCP PHENCYCLIDINE	☐	☐
1144	THC MARIJUANA	☐	☐	1135	AMP AMPHETAMINES	☐	☐
1135	MET METHAMPHETAMINE	☐	☐	A468	PPX PROPOXYPHENE	☐	☐
1133	OPI OPIATES	☐	☐	1147	BUP BUPRENORPHINE	☐	☐

SPECIAL INSTRUCTIONS

5

☐ Covid-19 AntiBody Test (SST)

☐ Covid-19 (Swab)

6 PATIENT AUTHORIZATION

I certify that I have voluntarily provided a fresh and unadulterated urine specimen for analytical testing. The information on this form and on the label affixed to the specimen cup is accurate. I authorize Toplab to release the results of this testing to the treating authorized healthcare provider or facility. I hereby authorize my insurance plan to be billed and benefits to be paid directly to Toplab for services I received. I acknowledge that Toplab may be an out-of-network provider with my insurer. I am also aware that in some circumstances my insurer will send the payment directly to me. I agree to endorse insurance check and forward it to Toplab within 30 days of receipt. Failure to do so may result in my account being forwarded to Collections and reported to a Credit Bureau. I understand that Toplab may use my specimen and any testing performed on that specimen, for research, development and potential publication purposes, so long as the information has been properly de-identified pursuant to law.

Patient Signature ____ Date ____

Pt Name ____ Date ____/____/____

Donor Intials ____ Date of Birth ____/____/____

06182019