# TOPLAB

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

## 1 PRACTICE INFORMATION

Healthcare Provider 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
______________ ___/___/___ Last Use
______________ ___/___/___ Last Use
______________ ___/___/___ 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 | ☐ | ☐ |
| 485 | 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 PERFORM DEFINITIVE TEST FOR SPECIFIC DRUG

☐ Include All Tests ☐ Urine Test ☐ Oral Swabs* Only applies to tests marked with (*)

☐ Specimen Validity Testing (pH,Specific Gravity, Creatine) ☐ Screen All ☐ Screen and Confirm Positive Screening Results

☐ **ANALGESICS ( )**
- ☐ Acetaminophen

☐ **ANTICONVULSANTS (D087)**
- ☐ Gabapentin*
- ☐ Pregabalin*

☐ **ANTIDEPRESSANTS (D088)**
- ☐ Amitriptyline*
- ☐ Duloxetine
- ☐ Norfluoxetine
- ☐ Nortriptyline*
- ☐ Paroxetine
- ☐ Velafaxine

☐ **BENZODIAZEPINES (D089)**
- ☐ Alpha-Hydroxyalprazolam*
- ☐ Alpha-Hydroxymidazolam
- ☐ Alpha-Hydroxytriazolam
- ☐ Alprazolam*

☐ **BENZODIAZEPINES (cont)**
- ☐ 7-Aminoclonazepam*
- ☐ 7-Aminoflunitrazepam
- ☐ Clonazepam*
- ☐ N-Desmethylflunitrazepam
- ☐ Diazepam*
- ☐ Flurazepam*
- ☐ Flunitrazepam*
- ☐ 2-Hydroxyethylflurazepam
- ☐ Lorazepam*
- ☐ Midozolam*
- ☐ Oxazepam*
- ☐ Temazepam*

☐ **CANNABINOID**
- ☐ THC*

☐ **ILLICITS (D006)**
- ☐ 6 MAM (Heroin Metabolite)*
- ☐ Acetyl Fentanyl
- ☐ Benzoylecgonine (Cocaine)*
- ☐ Ketamine

☐ **ILLICITS (cont)**
- ☐ MDA*
- ☐ MDEA*
- ☐ MDMA (Ecstacy)*
- ☐ Methamphetamine*
- ☐ Phencyclidine (PCP)

☐ **ILLICITS: SYNTHETICS (D085)**
- ☐ Spices (Syn. THC)

☐ **MUSCLE RELAXANTS (D008)**
- ☐ Carisprodol
- ☐ Cyclobenzaprine
- ☐ Meprobamate*

☐ **OPIATES/OPIOIDS (D084)**
- ☐ Codeine*
- ☐ Hydrocodone*
- ☐ Hydromorphone*
- ☐ Morphine*
- ☐ Noroxycodone*
- ☐ Oxycodone*
- ☐ Oxymorphone*

☐ **OPIOIDS: SYNTHETIC (D086)**
- ☐ 6-Beta-Naltrexol
- ☐ Buprenorphine*
- ☐ Fentanyl*
- ☐ Meperidine*
- ☐ Methadone/EDDP*
- ☐ Mitragynine
- ☐ Naloxone (Suboxone)*
- ☐ Naltrexone (Vivitrol)*
- ☐ N-Desmethyltapentadol
- ☐ Norbuprenorphine*
- ☐ Norfentanyl Oxalate*
- ☐ Normerperidine
- ☐ O-Desmethyl-Cis-Tramadol*
- ☐ Tramadol*
- ☐ Tapentadol*

☐ **SEDATIVE HYPNOTICS (D027)**
- ☐ Zaleplon
- ☐ Zolpidem

☐ **STIMULANTS (D001)**
- ☐ Amphetamine*
- ☐ Butylone
- ☐ Ethylone
- ☐ MDPV*
- ☐ Mephedrone
- ☐ Methylone
- ☐ Methylphenidate
- ☐ Naphyrone

## 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___/___/___

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