


Diagnosis Code(s): _____		CLIA ID# 39D2010034																																																																					
SteelFusion Clinical Toxicology Laboratory, LLC 1103 Donner Ave • Monessen, PA 15062 Phone: 724-691-0263 • Fax: 724-420-5783 		FACILITY/PRACTICE / PROVIDER INFORMATION NAME OF ORDERING PROVIDER/LOCATION: Cypress Pointe Surgical Hospital																																																																					
Patient Information (Please include copy of Patient Face Sheet Demographics and Insurance Information with this form)		Insurance Information: <input type="checkbox"/> Self Pay																																																																					
Patient Name /Medical Record Number Address: Phone: _____ DOB: / / _____ SEX: M F		Primary Insurance Name: _____ Group: _____ ID#: _____ Secondary Insurance Name: _____ Group: _____ ID#: _____																																																																					
Specimen Collection Type (circle): Urine Oral Fluid		Check Patient's Currently Prescribed Medications																																																																					
Date Collected: / / Time Collected: _____		<input type="checkbox"/> Acliq <input type="checkbox"/> Butalbital <input type="checkbox"/> Dilaudid <input type="checkbox"/> Halcion <input type="checkbox"/> Lyrica <input type="checkbox"/> Opana <input type="checkbox"/> Pregabalin <input type="checkbox"/> Tofranil <input type="checkbox"/> Adapin <input type="checkbox"/> Butrans <input type="checkbox"/> Dolophine <input type="checkbox"/> Hydrocet <input type="checkbox"/> Maxidone <input type="checkbox"/> Oramorph SR <input type="checkbox"/> Propoxyphene <input type="checkbox"/> Tramadol <input type="checkbox"/> Adderall <input type="checkbox"/> Carisoprodol <input type="checkbox"/> Doxepin <input type="checkbox"/> Hydrocodone <input type="checkbox"/> Meperidine <input type="checkbox"/> Oxazepam <input type="checkbox"/> Restoril <input type="checkbox"/> Tylenol 3/4/5 <input type="checkbox"/> Alprazolam <input type="checkbox"/> Clonazepam <input type="checkbox"/> Duragesic <input type="checkbox"/> Hydrogesic <input type="checkbox"/> Methadone <input type="checkbox"/> Oxy IR <input type="checkbox"/> Ritalin <input type="checkbox"/> Tylox <input type="checkbox"/> Ambien <input type="checkbox"/> Codeine <input type="checkbox"/> Elavil/Endep <input type="checkbox"/> Hydromorphone <input type="checkbox"/> Temazepam <input type="checkbox"/> Oxycodone <input type="checkbox"/> Roxanol <input type="checkbox"/> Ultracet <input type="checkbox"/> Amitriptyline <input type="checkbox"/> Concerta <input type="checkbox"/> Endocet <input type="checkbox"/> Hydrostat IR <input type="checkbox"/> Morphine <input type="checkbox"/> Oxycotin <input type="checkbox"/> Roxicodone <input type="checkbox"/> Ultram <input type="checkbox"/> Amphetamine <input type="checkbox"/> Cyclobenzaprine <input type="checkbox"/> Fentanyl <input type="checkbox"/> Kadian <input type="checkbox"/> MS Contin <input type="checkbox"/> Oxymorphone <input type="checkbox"/> Serax <input type="checkbox"/> Valium																																																																					
Specimen Validity Testing Performed: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		Collector's Initials: _____																																																																					
URINE: Temperature read within 4 minutes and is within range degrees F): (94-100) <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Amytal <input type="checkbox"/> Dalmene <input type="checkbox"/> Fentora <input type="checkbox"/> Ketamine <input type="checkbox"/> MSIR <input type="checkbox"/> Pamalor <input type="checkbox"/> Soma <input type="checkbox"/> Vicodin <input type="checkbox"/> Anexia <input type="checkbox"/> Darvocet <input type="checkbox"/> Fexmid <input type="checkbox"/> Klonopin <input type="checkbox"/> Numbital <input type="checkbox"/> Pentobarbital <input type="checkbox"/> Sublimaze <input type="checkbox"/> Vicoprofen <input type="checkbox"/> Ativan <input type="checkbox"/> Darvon <input type="checkbox"/> Fioricet <input type="checkbox"/> Lorazepam <input type="checkbox"/> Neurontin <input type="checkbox"/> Percocet <input type="checkbox"/> Subox one <input type="checkbox"/> Xanax <input type="checkbox"/> Avinza <input type="checkbox"/> Demerol <input type="checkbox"/> Flexeril <input type="checkbox"/> Lorcet <input type="checkbox"/> Norco <input type="checkbox"/> Percodan <input type="checkbox"/> Subutex <input type="checkbox"/> Zolpidem <input type="checkbox"/> Buprenex <input type="checkbox"/> Dexedrine <input type="checkbox"/> Flurazepam <input type="checkbox"/> Lortab <input type="checkbox"/> Nordiazepam <input type="checkbox"/> Phenobarbital <input type="checkbox"/> Other _____ <input type="checkbox"/> Buprenorphine <input type="checkbox"/> Diazepam <input type="checkbox"/> Gabapentin <input type="checkbox"/> Luminal <input type="checkbox"/> Nucynta <input type="checkbox"/> Phentermine <input type="checkbox"/> Other _____																																																																					
Analyzer (Instrumented assay) Test Cup/Kit –Read by Individual Test Cup/Kit –Read by Reader (instrument) Record <u>ALL</u> Presumptive Test Cup/Kit Results here OR Provide Analyzer Results Report with this Requisition Form.		<table border="1" style="width:100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th>Lab Test Order</th> <th>AMP</th> <th>BAR</th> <th>BUIP</th> <th>BZO</th> <th>COC</th> <th>mAMP</th> <th>MDMA</th> <th>MTD</th> <th>OP1</th> <th>OXY</th> <th>PCP</th> <th>PPX</th> <th>TCA</th> <th>THC</th> <th>ETOH</th> <th>EIG</th> <th>CAR</th> <th>EDDP</th> <th>FEN</th> <th>6-AM</th> <th>TRAM</th> </tr> </thead> <tbody> <tr> <td>Positive</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Negative</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table>		Lab Test Order	AMP	BAR	BUIP	BZO	COC	mAMP	MDMA	MTD	OP1	OXY	PCP	PPX	TCA	THC	ETOH	EIG	CAR	EDDP	FEN	6-AM	TRAM	Positive																							Negative																						
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Please Read the Following Notice Concerning Medically Necessary and Reasonable Testing: Notice to Ordering Practitioner: <i>Only tests that are medically necessary and reasonable for the diagnosis or treatment of a patient, and individualized to that patient, will be reimbursed. Practitioners should consult with Local Coverage Determinations (Medicare) and Medical Policies (Commercial). Any person who orders or influences the ordering of medically unnecessary or unreasonable tests for which reimbursement is claimed may be subject to action that includes but is not limited to civil penalties under the False Claims Act. Note: Many payers have limitations on the number or frequency of tests that may be conducted, please consult payer guidance on routine testing for more information.</i>		Patient Consent to Testing, Assignment of Benefits and Use of Results: <i>I consent to both the collection of a specimen and drug testing analysis. I certify that I have not adulterated my sample in any manner; that the information and numbers provided on this form and my initial on the label attached to the specimen bottle are correct; and I authorize SteelFusion Clinical Toxicology Laboratory to test and release the test results to the ordering practitioner/provider or authorized staff. Insurance Release: I request that payment of authorized insurance, as indicated, be made to the Laboratory for the laboratory services ordered by my practitioner. I authorize my provider and their staff, as well as my insurance company (if any) to release to the Laboratory and its agents, any information needed to determine benefits for laboratory services. I understand that I am responsible for payment of any deductibles or co-insurance charges. If the self-pay box is marked, I accept full financial responsibility for payment associated with these laboratory services.</i>																																																																					
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