

QUALITY AND ACCURACY ARE OUR TOP PRIORITY

LAB AND MEDICAL FORMS

PROVIDING LAB AND MEDICAL FORMS FOR OVER 40 YEARS



MARKETS

- Laboratories
- Doctor's offices
- Clinics
- Hospitals
- Dental offices
- Chiropractic offices
- Dermatology offices
- Surgery centers



FEATURES

- Integrated labels or affixed labels (blown on or add-a-label)
- Customize location, size and quantity of labels
- Labels can be affixed to any ply of the form set
- Ability to add secure tamper evident labels
- Consecutive or static barcode numbering
- Human readable numbering
- Sequential numbering
- Continuous, single sheets, snap out, multi-part form options
- Lay flat liner - print on the back of the liner
- Printed black/white or color (up to 8 colors)
- Laser compatible
- Stock integrated options also available (blank)

URINE TOXICOLOGY REQUISITIONING

P: 904-241-7734 F: 904-241-7777
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CLIA: 12D098698

↑ FEEL HERE ↑



PB 06501

PRACTICE NAME:

PHYSICIAN NAME:

PHYSICIAN NAME:

Print Patient Name _____ Date (Mo - Day Yr) ____/____/____



POC URINE TOXICOLOGY REQUISITION

PATIENT INFORMATION			
Last Name		First Name	
Street Address		City	State
SSN	Date of Birth ____/____/____	Gender	Male Female
Zip Code			
BILLING & INSURANCE INFORMATION			
<input type="checkbox"/> Self Pay <input type="checkbox"/> Medicare/Tricare <input type="checkbox"/> Medicaid <input type="checkbox"/> Private <input type="checkbox"/> Workers Comp - Injury Date: _____ Employer: _____ Claim # _____			
Insurance Provider: please attach front & back copies of primary & secondary insurance cards. Policy # _____ Group # _____			
<small>I voluntarily consent to the collection and testing of my specimen and certify that the specimen identified on this form is my own, and has not been adulterated in any manner. I certify that the information provided on this form and on the specimen is accurate. Further, I authorize Urine Toxicology Requisitioning, to release the results of this testing to the ordering facility and/or my insurance company. I authorize my insurance company to pay and mail directly to Urine Toxicology Requisitioning and its affiliated laboratories all benefits for payment of services rendered. I also authorize Urine Toxicology Requisitioning and its affiliated laboratories to endorse any checks received on my behalf for payment of services provided. I hereby irrevocably assign to Urine Toxicology Requisitioning and its affiliated laboratories all benefits under any policy of insurance indemnity agreement, or any collateral source as defined by statute for services provided. This assignment includes all rights to collect benefits directly from my insurance company and all rights to proceed against my insurance company in any action including legal suit, if for any reason my insurance company fails to make payment to benefits due. This assignment also includes all rights to recover attorney fees and costs for suit action brought by the provider as my assignee.</small>			
Patient Signature (Required) _____ Date _____			
POCT SCREENING			
Pos. Neg.	Pos. Neg.	Pos. Neg.	Pos. Neg.
<input type="checkbox"/> (AMP)	<input type="checkbox"/> (BUP)	<input type="checkbox"/> (COC)	<input type="checkbox"/> (OPR)
<input type="checkbox"/> (BAR)	<input type="checkbox"/> (RZO)	<input type="checkbox"/> (MDMA)	<input type="checkbox"/> (OXY)
<input type="checkbox"/> (NET) <input type="checkbox"/> (MTD) <input type="checkbox"/> (PCP) <input type="checkbox"/> (TCA)			
DIAGNOSIS CODES			
ICD-10 Code(s) _____			
SPECIMEN INFORMATION			
Name of Collector	Collection Date ____/____/____	Time ____:____ am/pm	Sample temp. read within 4 min of collection & between 16-19°C <input type="checkbox"/> Yes <input type="checkbox"/> No
PRESCRIBED MEDICATION(S)			
<input type="checkbox"/> Medication List Attached <input type="checkbox"/> Patient Reports "No Medications"			
<input type="checkbox"/> Alprazolam	<input type="checkbox"/> Amitriptyline	<input type="checkbox"/> Amphetamine	<input type="checkbox"/> Buprenorphine
<input type="checkbox"/> Diazepam	<input type="checkbox"/> Borepin	<input type="checkbox"/> Fentanyl	<input type="checkbox"/> Fluazepam
<input type="checkbox"/> Methadone	<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> Methylenediphenate	<input type="checkbox"/> Morphine
<input type="checkbox"/> Zolpidem	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Oxycodone	<input type="checkbox"/> Oxazepam
<input type="checkbox"/> Carisoprodol	<input type="checkbox"/> Clonazepam	<input type="checkbox"/> Cyclobenzaprine	<input type="checkbox"/> Desipramine
<input type="checkbox"/> Gabapentin	<input type="checkbox"/> Hydrocodone	<input type="checkbox"/> Hydromorphone	<input type="checkbox"/> Lorazepam
<input type="checkbox"/> Quaalude	<input type="checkbox"/> Valium	<input type="checkbox"/> Xanax	<input type="checkbox"/> Tapentadol
<input type="checkbox"/> Other: _____			
ORDER SELECTION			
<input type="checkbox"/> Full Screen & Confirmation <input type="checkbox"/> Presumptive Reflex <input type="checkbox"/> Confirmation Only <input type="checkbox"/> Physician Preference <input type="checkbox"/> Physician Preference w/ Additional Testing			
<input type="checkbox"/> PRESUMPTIVE TESTING	<input type="checkbox"/> ALCOHOL	<input type="checkbox"/> AMPHETAMINES	<input type="checkbox"/> ANTIDEPRESSANTS
<input type="checkbox"/> Amphetamines	<input type="checkbox"/> BAC	<input type="checkbox"/> 6-Methylamphetamines	<input type="checkbox"/> 7-Hydroxyquetiapine
<input type="checkbox"/> Benzodiazepines	<input type="checkbox"/> BAC	<input type="checkbox"/> Amphetamine	<input type="checkbox"/> Amitriptyline
<input type="checkbox"/> Buprenorphine	<input type="checkbox"/> BAC	<input type="checkbox"/> MDMA	<input type="checkbox"/> Bupropion
<input type="checkbox"/> Cocaine	<input type="checkbox"/> BENZODIAZEPINES	<input type="checkbox"/> MDMA	<input type="checkbox"/> Citalopram
<input type="checkbox"/> Methadone	<input type="checkbox"/> 7-aminoclonazepam	<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> Desmethyldiazepam
<input type="checkbox"/> Quaalude	<input type="checkbox"/> 4-hydroxypropylthiuronium	<input type="checkbox"/> Methylenediphenate	<input type="checkbox"/> Doxapram
<input type="checkbox"/> Oxycodone	<input type="checkbox"/> Alprazolam	<input type="checkbox"/> Morphine	<input type="checkbox"/> Doxapram
<input type="checkbox"/> Phencyclidine	<input type="checkbox"/> Clonazepam	<input type="checkbox"/> Morphine	<input type="checkbox"/> Doxapram
<input type="checkbox"/> Propoxyphene	<input type="checkbox"/> Oxycodone	<input type="checkbox"/> Morphine	<input type="checkbox"/> Doxapram
<input type="checkbox"/> Tricyclic Anti-Depressants	<input type="checkbox"/> Phencyclidine	<input type="checkbox"/> Morphine	<input type="checkbox"/> Doxapram
<input type="checkbox"/> TAC	<input type="checkbox"/> Propoxyphene	<input type="checkbox"/> Morphine	<input type="checkbox"/> Doxapram
<input type="checkbox"/> Ecstasy	<input type="checkbox"/> Tricyclic Anti-Depressants	<input type="checkbox"/> Morphine	<input type="checkbox"/> Doxapram
<input type="checkbox"/> BARIOTURATES	<input type="checkbox"/> TAC	<input type="checkbox"/> Morphine	<input type="checkbox"/> Doxapram
<input type="checkbox"/> Butabarbital	<input type="checkbox"/> Ecstasy	<input type="checkbox"/> Morphine	<input type="checkbox"/> Doxapram
<input type="checkbox"/> Pentobarbital	<input type="checkbox"/> BARIOTURATES	<input type="checkbox"/> Morphine	<input type="checkbox"/> Doxapram
<input type="checkbox"/> Phenobarbital	<input type="checkbox"/> Butabarbital	<input type="checkbox"/> Morphine	<input type="checkbox"/> Doxapram
<input type="checkbox"/> Secobarbital	<input type="checkbox"/> Pentobarbital	<input type="checkbox"/> Morphine	<input type="checkbox"/> Doxapram
<small>* drugs available for Oral Fluid Testing</small>			
<small>I hereby authorize Urine Toxicology Requisitioning to perform the test(s) indicated on this requisition form. I certify that these services are medically necessary for the diagnosis and treatment of the patient's personal symptoms or medical history.</small>			
Authorized Physician Signature (Required) _____ Date _____			

CUSTOMIZED for your client's specific needs.

800.821.4021 wardkraft.com

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APPLICATIONS

- COVID-19 forms
- Pathology
- Urology test
- Dermatopathology
- HIV test forms
- Transfusion records
- Laboratory
- Chain of custody forms
- Specimen form
- Radiology
- Toxicology
- Other lab and medical forms



BENEFITS

- All under one roof - from printing and numbering individual parts and labels to combining form and label into a single form
- Highest quality and aggressive adhesive
- Fast turn times
- Feeds through printers without jamming - printing form and label in one pass
- Increased efficiencies and increased accuracy

When it comes to medical/lab forms - call someone you can TRUST!

From integrated to form/label combinations to multi-part forms - we got you covered.

800.821.4021 **wardkraft.com**