EXPRESS MEDICAL EXPERTS

# Toxicology Order Form

Phone: 904-647-8177
Fax: 904-683-5338

## REQUISITION ORDER

Ordering Physician NPI

Clinic/Facility Address

## PATIENT'S / INSURANCE INFORMATION

Last Name First Name Initial

DOB Sex: F or M

Address

City Sate Zip Code

Insurance

Member ID

**ATTACHED INSURANCE CARD IF NECESSARY**

## SPECIMEN DATA

Date Collected:____/____/____Time:____:____AM PM

Collector Name:____________________

## PATIENT'S PRESUMPTIVE POC RESULTS

☐ Please check if initial POC drug screen was performed and billed to the insurance company

| | POC RESULTS POS (+) | POC RESULTS NEG (-) |
|---|---|---|
| MARIJUANA [THC] | ☐ | ☐ |
| COCAINE [COC] | ☐ | ☐ |
| OPIATES [OPI] | ☐ | ☐ |
| AMPHETAMINES [AMP] | ☐ | ☐ |
| METHAMPHETAMINE [MET] | ☐ | ☐ |
| PHENCYCLIDINE [PCP] | ☐ | ☐ |
| ECSTASY [MDMA] | ☐ | ☐ |
| BARBITURATES [BAR] | ☐ | ☐ |
| BENZODIAZEPINES [BZO] | ☐ | ☐ |
| METHADONE [MTD] | ☐ | ☐ |
| TRICYCLICS/ANTIDEPRESSANTS [TCA] | ☐ | ☐ |
| OXYCODONE [OXY] | ☐ | ☐ |
| BUPRENORPHINE [BUP] | ☐ | ☐ |

## ICD-10 DIAGNOSIS CODE(S)

## SCREENING/PRESUMPTIVE TESTING

☐ PERFORM PRESUMPTIVE IMMUNOASSAY DRUG TEST AND CONFIRM ALL POSITIVES

☐ PERFORM PRESUMPTIVE IMMUNOASSAY DRUG TEST ONLY

## CONFIRMATION/DEFINITIVE LC-MS/MS TESTING

☐ CUSTOM PANEL ☐ CONFIRM ALL

☐ALCOHOL
- ☐ Ethyl Glucuronide
- ☐ Ethyl Sulfate

☐BARBITUATES
- ☐ Butalbital
- ☐ Pentobarbital
- ☐ Phenobarbital
- ☐ Secobarbital

☐BENZODIAZEPINES
- ☐ 7-aminoclonazepam
- ☐ Alpha-hydroxyalprazolam
- ☐ Alprazolam
- ☐ Diazepam
- ☐ Lorazepam
- ☐ Nordiazepam
- ☐ Oxazepam
- ☐ Temazepam

☐CANNABINOIDS
- ☐ JWH 18 4-OH Pentyl
- ☐ JWH 250-4-OH Pentyl
- ☐ JWH 73 3-OH Butyl
- ☐ THC-COOH (THCA)

☐CATHINONES
- ☐ Alpha PVP
- ☐ MDPV
- ☐ Methedrone
- ☐ Pentedrone
- ☐ Pentedrone Norephedrine

☐ECSTACY ANALOGS
- ☐ MDA
- ☐ MDEA
- ☐ MDMA
- ☐ Methylone

☐MUSCLE RELAXANTS
- ☐Carisoprodol
- ☐Cyclobenzaprine
- ☐Meprobamate

☐NICOTINE
- ☐Cotinine

☐OPIATES/OPIOIDS
- ☐6-MAM
- ☐Buprenorphine
- ☐Codeine
- ☐Desmethyltapentadol
- ☐EDDP
- ☐Fentanyl
- ☐Hydrocodone
- ☐Hydromorphone
- ☐Methadone
- ☐Morphine
- ☐Norbuprenorphine
- ☐Norfentanyl
- ☐Noroxycodone
- ☐Norpropoxyphene
- ☐O-Desmethyltramadol
- ☐Oxycodone
- ☐Oxymorphone
- ☐Propoxyphene
- ☐Tapentadol
- ☐Tramadol

☐OTHER PHARMACEUTICALS
- ☐Carbamazepine
- ☐Dextromethorphan
- ☐Gabapentin
- ☐Levetiracetam
- ☐Pregabalin

☐SEDATIVES
- ☐Zaleplon
- ☐Zolpidem
- ☐Zolpidem 6-Carboxylic

☐STIMULANTS
- ☐Amphetamine
- ☐Methamphetamine

☐TRICYCLICS/ANTIDEPRES-SANTS
- ☐Amitriptyline
- ☐Desipramine
- ☐Desmethylcitalopram
- ☐Doxepin
- ☐Fluoxetine
- ☐Hydroxybupropion
- ☐Imipramine
- ☐Nortriptyline
- ☐Sertraline

☐UNSPECIFIED ILLICITS
- ☐7-Hydroxymitragynine
- ☐Benzoylecgonine
- ☐PCP

## OTHER TESTS TO PERFORM

## PATIENT PRESCRIBED MEDICATIONS - Attach list if necessary

## PHYSICIAN SIGNATURE:

**Physician Signature** **Date**

THE SPECIMEN IDENTIFIED ON THIS FORM IS MY OWN. I HAVE NOT ALTERED IT IN ANY WAY AND VOLITARILY SUBMIT THIS SPECIMEN. I AUTHORIZE EXPRESS MED EXPERTS LLC(EME) TO RELEASE RESULTS TO ORDERING PROVIDER AND BILL TO MY INSURANCE ON MY BEHALF. I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO EME FOR SERVICES RENDERED. I ACKNOWLEDGE THAT I'M RESPONSIBLE FOR ANY OUTSTANDING BALANCES AND IF NOT PAID IN FULL ACCOUNT WILL BE FORWARDED TO COLLECTION OR LEGAL ACTION. SELF PATIENTS WILL BE BILLED DIRECTLY.

**Patient Signature** **Date**