

LAB REQUEST FORM

Express Medical Experts
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LABEL – LAB ONLY

PRACTICE INFORMATION

| | | |
|-----------------------|---------------------|----------|
| Facility/Clinic Name: | Ordering Physician: | NPI# |
| Address | City | State |
| | | Zip Code |

PATIENT INFORMATION: Please attached medication list & patient demographic sheet or complete the following section.

| | | | |
|---|---------------------|------------------|--|
| First Name: | Last Name: | DOB:(MM/DD/YYYY) | Sex: <input type="checkbox"/> F <input type="checkbox"/> M |
| Phone Number: | DOI (If applicable) | Email: | |
| Address | City | State | Zip Code |
| Race: <input type="checkbox"/> American Indian/Alaska <input type="checkbox"/> Black/African American <input type="checkbox"/> Multi Race <input type="checkbox"/> White <input type="checkbox"/> Hawaiian <input type="checkbox"/> Asian | | | |

BILLING INFORMATION: Please attached patient demographic sheet or complete the following section. Medicare Tricare Commercial Self-Pay

| | | |
|--------------------|------------|---------------|
| Insurance Company: | Member ID: | Group Number: |
|--------------------|------------|---------------|

| | | | | |
|-----------------------------|-----------------|-------|---------------------|---|
| SPECIMEN INFORMATION | Date Collected: | Time: | Collector Initials: | Specimen Type: <input type="checkbox"/> Urine |
|-----------------------------|-----------------|-------|---------------------|---|

TESTING INFORMATION

| | | | |
|--|--|--|--|
| <input type="checkbox"/> Urine Drug Screening Includes screening for: Amphetamine Benzodiazepine Buprenorphine Cocaine Methamphetamine Opiates Oxycodone PCP THC <input type="checkbox"/> Select this box to perform drug test and confirm all positives and prescribed medications. | <input type="checkbox"/> Toxicology Full Confirmation Panel (LCMS/MS Testing) <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> BENZODIAZEPINES 7-aminoclonazepam Alpha-hydroxyalprazolam Alprazolam Diazepam Lorazepam Nordiazepam Oxazepam Temazepam <input type="checkbox"/> ILLICITS MDA MDMA PCP Benzoylcegonine 6-MAM THC-COOH <input type="checkbox"/> SUBOXONE/OPIOID ANTAGONIST Buprenorphine Norbuprenorphine Naloxone <input type="checkbox"/> STIMULANTS/SYMPATHOMIMETIC Amphetamine Methamphetamine Methylphenidate <input type="checkbox"/> MUSCLE RELAXANTS/GABAPENTINOIDS Carisoprodol Cyclobenzaprine Gabapentin Pregabalin </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> OPIATES/OPIOIDS Codeine Morphine EDDP Methadone Fentanyl Norfentanyl Hydrocodone Hydromorphone O-Desmethyl-Cis-tramadol Tramadol Oxycodone Oxymorphone Tapentadol <input type="checkbox"/> NICOTINE Cotinine <input type="checkbox"/> ANTI-DEPRESSANTS Amitriptyline Desipramine Doxepin Fluoxetine Imipramine Nortriptyline </td> </tr> </table> | <input type="checkbox"/> BENZODIAZEPINES 7-aminoclonazepam Alpha-hydroxyalprazolam Alprazolam Diazepam Lorazepam Nordiazepam Oxazepam Temazepam <input type="checkbox"/> ILLICITS MDA MDMA PCP Benzoylcegonine 6-MAM THC-COOH <input type="checkbox"/> SUBOXONE/OPIOID ANTAGONIST Buprenorphine Norbuprenorphine Naloxone <input type="checkbox"/> STIMULANTS/SYMPATHOMIMETIC Amphetamine Methamphetamine Methylphenidate <input type="checkbox"/> MUSCLE RELAXANTS/GABAPENTINOIDS Carisoprodol Cyclobenzaprine Gabapentin Pregabalin | <input type="checkbox"/> OPIATES/OPIOIDS Codeine Morphine EDDP Methadone Fentanyl Norfentanyl Hydrocodone Hydromorphone O-Desmethyl-Cis-tramadol Tramadol Oxycodone Oxymorphone Tapentadol <input type="checkbox"/> NICOTINE Cotinine <input type="checkbox"/> ANTI-DEPRESSANTS Amitriptyline Desipramine Doxepin Fluoxetine Imipramine Nortriptyline |
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 ICD-10 Treatment Codes Z79.899: Long term use of medication Z79. 891: Long term (current) use of opiate analgesic. F11.20: Opioid dependence, uncomplicated Z91.14: History of noncompliance medical treatment F14.13: Cocaine abuse G89. 4: Chronic pain syndrome Other: _____ _____ _____ **Prescribed Medication:** Xanax Norco Oxycodone Ambien Hydrocodone Lyrica Morphine Suboxone Adderall Zolpidem Tramadol Gabapentin Other: _____ _____ _____ |

Requesting Provider Authorization:

| | | |
|---------------|--------------------|-------|
| Provider Name | Provider Signature | Date: |
|---------------|--------------------|-------|

The provider certifies that the requested tests are medically necessary, that the medical necessity of requested tests is documented in the patient's chart, and the need for the requested tests has been explained to the patient. The provider also agrees to provide chart notes or other documentation within 72 hours when requested by patients and/or insurers. The provider recognizes that the Centers for Medicare and Medicaid Services (CMS) and, increasingly, commercial insurers hold that toxicology confirmation testing is indicated when a toxicology screen is not consistent with the patient's medical history, prescribed medications, clinical presentation or the patient's own statements. Toxicology confirmation testing may also be medically necessary when the provider determines toxicology screening will not provide the necessary breadth or quantification of results to meet the patient's medical needs.