CLIAwaived™ Inc.
The Point-of-Care Marketplace™

URINE INITIAL DRUG SCREEN RESULT FORM

Instant Drug Test Cup Plus — From 5-19 Tests — 6AM / AMP / BAR / BUP / BZO / COC / EDDP / FEN / nFEN / MDMA / MET / MOR / MTD / OPI / OXY / PCP / PPX / TCA / THC

Specimen ID Number ____________________

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

COLLECTION SITE / COMPANY NAME ____________________

NAME ____________________

ADDRESS ____________________ **SUITE** __________

CITY ____________________ **STATE** __________ **POSTAL CODE** __________

PHONE ____________________ **FAX** ____________________

DONOR SSN, DRIVER'S LICENSE or EMPLOYEE I.D. NO. | | | | | | | | | | | | | | | | ***ID VERIFIED BY:*** ☐ ***PHOTO ID*** ☐ ***E. REP.***

DONOR NAME: *Last:* | | | | | | | | | | | | | *First:* | | | | | | | | | | | |

REASON FOR TEST: ☐ Pre Employment ☐ Random ☐ Reasonable Suspicion / Cause ☐ Post Accident ☐ Return to Duty ☐ Follow Up ☐ Other

COLLECTOR NAME (PRINT) ____________________ Collector Phone No. (   ) __________

Collector Fax No. (   ) __________

Read specimen temperature with in (4) minutes: ☐ Yes, 90° - 100°F (32° - 38°C) ☐ No, record specimen temperature here ______________

STEP 2: COMPLETED BY DONOR

DONOR CONSENT: I certify that I provided my specimen to the collector, that the specimen container was sealed with a tamper proof seal in my presence and that the information provided on this form and on the label affixed to the specimen container is correct. I hereby give permission for the release of the results of these tests to the health care provider. In the case of screening for employment or pre-employment, I also authorize release of the results of these tests to my employer or prospective employer and / or their authorized health care provider.

X ____________________ *Date (Mo/Day/Yr)* __________

Signature of Donor

____

(Print) Donor's Name (First, MI, Last)

Daytime Phone: ______________________ Evening Phone: ______________________ Date of Birth: __________ *(Mo/Day/Yr)*

STEP 3: COMPLETED BY COLLECTOR — INITIAL TEST RESULTS

☐ **ON-SITE SCREENING DEVICE**
preliminary results
(Complete for on-site device results)

Pad	Test	Normal	Abnormal
OX	Oxidant	☐	☐
S.G.	Specific Gravity	☐	☐
pH	pH	☐	☐
Ni	Nitrite	☐	☐
GL	GL	☐	☐
CR	Creatinine	☐	☐

Lot #: ______________________

Exp. Date: ______________________

Screen performed by:
X ____________________

Date: ______________________

Remarks: ______________________

____

DRUG NAME

Drug	NEG	PRES.	N/T	Drug	NEG	PRES.	N/T
6-Acetylmorphine (6AM)	☐	☐	☐	Methamphetamine (MET)	☐	☐	☐
Amphetamine (AMP)	☐	☐	☐	Morphine (MOR)	☐	☐	☐
Barbiturates (BAR)	☐	☐	☐	Methadone (MTD)	☐	☐	☐
Buprenorphine (BUP)	☐	☐	☐	Opiates (OPI)	☐	☐	☐
Benzodiazepines (BZO)	☐	☐	☐	Oxycodone (OXY)	☐	☐	☐
Cocaine (COC)	☐	☐	☐	Phencyclidine (PCP)	☐	☐	☐
Methadone Metabolite (EDDP)	☐	☐	☐	Propoxyphene (PPX)	☐	☐	☐
Fentanyl (FEN)	☐	☐	☐	Tricyclic Antidepressants (TCA)	☐	☐	☐
Norfentanyl (nFEN)	☐	☐	☐	Marijuana (THC)	☐	☐	☐
Ecstasy (MDMA)	☐	☐	☐				
Other ______________	☐	☐	☐				

ALCOHOL SCREEN (If Performed)

	NEG	PRES.	N/T
Results	☐	☐	☐

STEP 4: COLLECTOR CERTIFICATION

COLLECTOR CERTIFICATION: I certify that the specimen given to me by the donor identified above was collected, labeled, sealed & released as noted in accordance with applicable requirements.

X ____________________

Signature of Collector

X ____________________

(Print) Collector's Name (First, MI, Last)