heliosDX

ORAL TOXICOLOGY REQUISITION

Pt. Name

Date

Donor Initials

Date of Birth

* SPECIMEN INFORMATION

Date Collected

Time Collected

Collector's Name

Temperature read within 4 min and within range of 32.5-37.7°C (90.5-100°F)? ☐ YES ☐ NO

*SPECIMEN TYPE ☐ URINE ☐ ORAL FLUID

CLIENT INFORMATION

A. RECORD POINT-OF-CARE RESULTS

NOTE: if Point-of-Care result is NOT marked, it will default to a Negative (-) result.

MEDICATION OR DRUG	Pos (+)	Neg (-)	Confirm Results	MEDICATION OR DRUG	Pos (+)	Neg (-)	Confirm Results
1. Amphetamines	☐	☐	☐	8. Methadone	☐	☐	☐
2. Barbiturates	☐	☐	☐	9. Oxycodone	☐	☐	☐
3. Benzodiazepines	☐	☐	☐	10. Opioids/ Opiates	☐	☐	☐
4. Buprenorphine	☐	☐	☐	11. Methamphetamine	☐	☐	☐
5. Cocaine	☐	☐	☐	12. Ecstasy	☐	☐	☐
6. Phencyclidine (PCP)	☐	☐	☐	13. Tricyclic Antidepressants	☐	☐	☐
7. Marijuana (THC)	☐	☐	☐				

PATIENT INFORMATION * Indicates required field

* Last Name

* First Name

* Date of Birth (MM/DD/YY)

SSN

☐ M ☐ F

* Sex

Phone (Day)

(Evening)

Insured's Address Apt. City State Zip

INSURANCE INFORMATION *INCLUDE COPY OF INSURANCE CARD

Insured's Name (if different from Patient)

Primary Insurance Name & Plan

Address (Insurance)

Policy I.D. #

Group / Plan / Book #

DIAGNOSTIC CODE(S)

*

PHYSICIAN AUTHORIZATION

The ordering physician or his/ her authorized representative must sign his/ her name and indicate the date the test is ordered. The signature constitutes a certification that, with respect to tests reimbursed by Medicare or other third party payers, the testing is medically necessary and the results will be used in the management of the patient.

* Physician Signature

Date

B. TEST OPTIONS

- ☐ Presumptive drug screen (DRUGS 1-10 SECTION A)
- ☐ Confirm all positives
- ☐ Confirm all prescribed medications
- ☐ Perform Specimen Validity (*Creatinine, *pH, *Specific Gravity)
- ☐ Test all drugs listed in Section C
- ☐ Oral Fluid Confirmation (Section C)
- ☐ Methamphetamine D/L isomers (U)
- ☐ Custom Panel

C. CONFIRM BY DRUG CLASS OR INDIVIDUAL DRUG

☐ ILLICITS (Mark if prescribed)
- ○ 6- MAM (Heroin Metabolite)
- ○ Alpha-PVP (U)
- ○ Benzoylecgonine (Cocaine)
- ○ Ketamine (U)
- ○ MDA
- ○ MDMA (Ecstasy)
- ○ Mitragynine (Kratom) (U)
- ○ Norketamine (U)
- ○ Phencyclidine (PCP) (U)

☐ CANNABANOIDS (THC)
- ○ Delta-9 THC (O)
- ○ THC (U)

☐ AMPHETAMINES
- ○ Amphetamine
- ○ Methamphetamine

☐ ANTI-CONVULSANTS
- ○ Gabapentin
- ○ Pregabalin

☐ BARBITURATES
- ○ Butalbital (U)
- ○ Pentobarbital (U)
- ○ Phenobarbital (U)
- ○ Secobarbital (U)

☐ BENZODIAZEPINES
- ○ 7-Aminoclonazepam
- ○ Alprazolam
- ○ Alpha-hydroxyalprazolam (U)
- ○ Clonazepam
- ○ Diazepam
- ○ Flunitrazepam (U)
- ○ Flurazepam (U)
- ○ Lorazepam
- ○ Midazolam (U)
- ○ Nordiazepam (U)
- ○ Oxazepam
- ○ Temazepam
- ○ Triazolam (U)

☐ ANTI-DEPRESSANTS
- ○ Duloxetine
- ○ Trazodone (U)
- ○ Quetiapine (Seroquel) (U)

☐ SSRI
- ○ Fluoxetine
- ○ Paroxetine (U)
- ○ Sertraline
- ○ Venlafaxine

☐ TCAs
- ○ Amitriptyline
- ○ Desipramine (O)
- ○ Doxepin
- ○ Imipramine (O)
- ○ Nortriptyline

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

☐ NON BENZODIAZEPINE HYPNOTIC
- ○ Zolpidem
- ○ Zolpidem-Caboxyl (U)

☐ NON OPIOID ANALGESICS
- ○ O-Desmethyltramadol (U)
- ○ Tapentadol
- ○ Tramadol

☐ OPIOIDS/OPIATES
- ○ Codeine
- ○ Buprenorphine
- ○ Dihydrocodeine (U)
- ○ EDDP (U)
- ○ Fentanyl
- ○ Hydrocodone
- ○ Hydromorphone
- ○ Meperidine (Demerol)
- ○ Methadone
- ○ Morphine
- ○ Naloxone
- ○ Naltrexone
- ○ Norbuprenorphine (U)
- ○ Norfentanyl (U)
- ○ Normeperidine (Nordemerol) (U)
- ○ Norhydrocodone (U)
- ○ Norpropoxyphene (U)
- ○ Noroxycodone (U)
- ○ Oxycodone
- ○ Oxymorphone
- ○ Propoxyphene (U)

☐ OTHER TESTS
- ○ Cotinine
- ○ Dextromethorphan (U)
- ○ Dextrorphan (U)
- ○ Phentermine (U)
- ○ Ritalinic Acid (U)

☐ ALCOHOL METABOLITES
- ○ ETG/ETS (U)

☐ SYNTHETIC CANNABINOIDS
- ○ JWH-018 Pentanoic Acid
- ○ UR-144 (O)

☐ SPECIMEN VALIDITY
- Creatine (U)
- pH (U)
- Specific Gravity (U)

*(U) - ONLY AVAILABLE FOR URINE SAMPLE. (O) - ONLY AVAILABLE FOR ORAL FLUID SAMPLE.

PATIENT AUTHORIZATION

I certify that I have voluntarily provided a fresh and unadulterated urine specimen for analytical testing. The information provided on this form and on the label affixed to the specimen cup is accurate. I authorize heliosDX to release the result of this testing to the authorized treating healthcare provider or facility. I hereby authorize my insurance benefits to be paid directly to heliosDX for services I have received. I acknowledge that heliosDX may be an out-of-network provider with my insurer. I am also aware that in some circumstances my insurer will send the payment directly to me. I agree to endorse the insurance check and forward it to heliosDX within 30 days of receipt. I understand that heliosDX may use my specimen and any testing performed on that specimen for research, development, and potential publication purposes, as long as the information has been properly de-identified pursuant to the law. heliosDX may request medical records from the provider to get reimbursed by the insurance carrier.

*** Patient Signature**

Date

When ordering tests for which Medicare reimbursement will be sought, Physicians (or other individuals authorized by law to order tests) should only order tests that are medically necessary for the diagnosis or treatment of the patient, rather than for screening purposes.
Go to our website, www.heliosdx.com, for important information regarding responsible ordering.

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