

Initial Drug Screen Result Form



Specimen ID Number: _____

Collection Test Date: _____

Company Information: (Company administering screening)	Office Use Only	
Company Name _____ Address _____ Suite _____ City _____ State _____ Postal Code _____ Collector's Name _____ Phone _____ Fax _____	Office Use Only	
Donor Information: (Person being tested)		
Donor's Name _____ ID# or SSN _____ Identification Type _____ Expiration _____ Notes _____ _____		

Certification Information: (Must be signed by both Donor and Collector)
<p><i>I hereby certify that the specimen provided is my own and has not been substituted or adulterated. I further agree and grant permission for the testing of my specimen for drug metabolites and/or alcohol.</i></p> <p>_____</p> <p>Donor's Signature _____ Date _____</p> <p><i>I hereby certify that I collected the specimen provided by the aforementioned donor and that, to the best of my knowledge, it was not substituted or adulterated. The specimen temperature and color were acceptable.</i></p> <p>_____</p> <p>Collector's Signature _____ Date _____</p>

Initial Screen Results: (All "Positive" results must be confirmed by GC/MS confirmation)					
Drug Name	Device Code	Negative	Positive	Not Tested	Adulteration Panel Results
Cocaine	COC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	(see color chart and package insert for interpretation) <input type="checkbox"/> Oxidant: In Range <input type="checkbox"/> OX Other _____ <input type="checkbox"/> Specific Gravity: In Range <input type="checkbox"/> S.G Other _____ <input type="checkbox"/> pH: In Range <input type="checkbox"/> pH Other _____
Marijuana	THC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Opiates/Morphine	OPI/MOR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Amphetamines	AMP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methamphetamine	mAMP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Phencyclidine	PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Benzodiazepine	BZO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Barbiturates	BAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methadone	MTD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tricyclic Antidepressants	TCA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oxycodone	OXY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene	PPX	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methylenedioxymethamphetamine	MDMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Alcohol Screen	ALC	<input type="checkbox"/>	Level _____		

Last Name _____
First Name _____