



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 _____ | |
| 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"/> | <p>(see color chart and package insert for interpretation)</p> <p><input type="checkbox"/> Oxidant: In Range <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> OX Specific Gravity: In Range <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> S.G pH: In Range <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> pH Other _____</p> |
| 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 _____ | | In Range <input type="checkbox"/> Other _____ |

Last Name

First Name