ORAL FLUIDS TOXICOLOGY REQUISITION

HDx Labs
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Medical Director: Jennifer Loch, DO
CLIA #10D2281222

CLIENT INFORMATION

Clinic:
Address:
Phone:
Provider:

*Please attach a copy of the patient face sheet and insurance provider information to this form.

PATIENT INFORMATION

Check One: ☐ Male ☐ Female

First: Last:
DOB: SSN:
Address:
Email: Phone:

INSURANCE INFORMATION: BILLING

☐ Insurance ☐ Patient
☐ Clinic ☐ Worker's Comp.
*If Worker's Comp, please attach data sheet.
Injury Date:

CONSENT TO TESTING

The specimen identified on this form is my own. I have not adulterated it in any way. I a submitting this specimen for analysis by my healthcare provider and/or third-party laboratory. I authorize the laboratory to release the results of this test to the ordering healthcare provider. The laboratory is authorized to bill my insurance provider and to receive payment of benefits for the tests my healthcare provider orders. I further authorize the laboratory and my healthcare provider to release to my insurance provider any medical information necessary to process this claim. HDx Labs accepts payments from many healthcare insurance companies. HDx Labs will bill patients for insurance deductibles, co-payments, and co-insurance amounts deemed by the insurance company to be the responsibility of the patient. HDx Labs will bill patients the cost of services if no coverage is available. HDx Labs will work with patients on an individual basis to establish payment options on any outstanding balance through the Financial Assistance Program. Uninsured Patients will be billed directly. Oral Fluids to be performed by: Tribal Diagnostics, 3600 S. Lakeside Dr. Oklahoma City, OK 73179. CLIA # 37D2113383, in partnership with HDx Labs.

SPECIMEN COLLECTION

Collector:
Date/Time:

PROVIDER SIGNATURE:

In my professional judgment, the specified t e sts a r e m e dically necessary. Documentation to support necessity for all tests ordered should be recorded in the patient's chart.

PATIENT SIGNATURE: _____ **DATE:**

ICD-10 1 | 2 | 3 | 4 | 5

DATE REC'D
(BY LAB)

MEDICATION INFORMATION:

☐ Mark prescribed medication ☐ Medication list attached ☐ Patient reports "No Medication"

CONFIRMATION (LC/MS/MS)

☐ Opiates/Opioids — Prescribed

- ☐ **Opiates**
  - Codeine ☐
  - Morphine ☐
  - Hydrocodone ☐
  - Hydromorphone ☐
- ☐ **Oxycodone** ☐
  - Oxymorphone ☐
- ☐ **Fentanyl** ☐
- ☐ **Methadone** ☐
- ☐ **Tramadol** ☐
- ☐ **Tapentadol** ☐
- ☐ **Buprenorphine** ☐

☐ Opiate Analogues — Prescribed

- **Meperidine** ☐
- **Naloxone** ☐
- **Naltrexone** ☐

☐ Cannabinoids — Prescribed

- **CBD** ☐
- **THC** ☐

☐ Stimulants — Prescribed

- ☐ **Methylphenidate** ☐
- ☐ **Amphetamines**
  - ☐ Amphetamine ☐
  - ☐ Methamphetamine
  - ☐ Phentermine ☐

☐ TCAs — Prescribed

- ☐ **Amitriptyline** ☐
- ☐ **Nortriptyline** ☐
- ☐ **Clomipramine** ☐
- ☐ **Desipramine** ☐
- ☐ **Doxepin** ☐
- ☐ **Imipramine** ☐

☐ Benzodiazepines — Prescribed

- **Alprazolam** ☐
- **Clonazepam** ☐
  - 7-aminoclonazepam
- **Diazepam** ☐
  - Nordiazepam
  - Temazepam ☐
  - Oxazepam ☐
- **Lorazepam** ☐

☐ Ketamine — Prescribed

- ☐ **Ketamine** ☐

☐ Sedative Hypnotics — Prescribed

- **Zolpidem** ☐

☐ Anticonvulsants — Prescribed

- ☐ **Gabapentin** ☐
- ☐ **Pregabalin** ☐

☐ Antidepressants — Prescribed

- **Bupropion** ☐
- **Venlafaxine** ☐

☐ Antipsychotics — Prescribed

- ☐ **Risperidone** ☐

☐ Muscle Relaxants — Prescribed

- ☐ **Carisoprodol** ☐
  - ☐ Meprobamate ☐
- ☐ **Cyclobenzaprine** ☐

☐ SNRIs/SSRIs — Prescribed

- ☐ **Citalopram** ☐
- ☐ **Duloxetine** ☐
- ☐ **Fluoxetine** ☐
- ☐ **Paroxetine** ☐
- ☐ **Sertraline** ☐

☐ Alkaloids

- **Cotinine (tobacco)**
- **Mitragynine (kratom)**

☐ Illicits

- ☐ **6-acetylmorphine**
- ☐ **Cocaine**
  - Benzylecgonine
- ☐ **MDMA**
- ☐ **Phencyclidine (PCP)**

POINT OF CARE RESULTS

	Pos.	Neg.		Pos.	Neg.
Amphetamines:	☐	☐	MDMA	☐	☐
Barbiturates:	☐	☐	Oxycodone	☐	☐
Opiates:	☐	☐	Phencyclidine	☐	☐
Methamphetamines:	☐	☐	Buprenorphine	☐	☐
Methadone:	☐	☐	Cocaine	☐	☐
THC:	☐	☐	Benzodiazepines	☐	☐

REQUIRED ATTACHMENTS

1) Clear copy of front and back of insurance
2) Copy of patient's demographics
3) Copy of current driver's license
4) Prior Authorization or Accident Form (if applicable)
5) If Worker's Comp. claim, SSN required in Patient Info

AFFIX TO TUBE

Patient Name
Date of Birth