Dynix Diagnostix
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Fort Pierce, FL 34946
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Toxicology Laboratory Request
T60000

CLINIC/PHYSICIAN INFORMATION

PATIENT'S / INSURANCE INFORMATION

Last Name First Name MI

__/__/__ D.O.B. M ☐ F ☐ XXX / XX / ____ Last 4 digits of SS#

Address

City, State ZIP

Phone Number

Insurance

Policy Number Group Number

☐ Insurance ☐ Patient Pay

PLEASE ATTACH COPY OF PATIENT FACE SHEET AND INSURANCE CARD

SPECIMEN DATA

Date Collected:_____/_____/_____ Time:_____:_____ AM PM

Collector Name:_____

PATIENT'S PRESUMPTIVE POC RESULTS

☐ Please check if initial POC drug screen was performed and billed to the insurance company

	POC RESULTS POS (+)	POC RESULTS NEG (-)
MARIJUANA [THC]	☐	☐
COCAINE [COC]	☐	☐
OPIATES [OPI]	☐	☐
AMPHETAMINES [AMP]	☐	☐
METHAMPHETAMINE [MET]	☐	☐
PHENCYCLIDINE [PCP]	☐	☐
ECSTASY [MDMA]	☐	☐
BARBITURATES [BAR]	☐	☐
BENZODIAZEPINES [BZO]	☐	☐
METHADONE [MTD]	☐	☐
TRICYCLICS/ANTIDEPRESSANTS [TCA]	☐	☐
OXYCODONE [OXY]	☐	☐
BUPRENORPHINE [BUP]	☐	☐

ICD-10 DIAGNOSIS CODE(S)

_____ _____

_____ _____

SCREENING/PRESUMPTIVE TESTING

☐ PERFORM PRESUMPTIVE IMMUNOASSAY DRUG TEST AND CONFIRM ALL POSITIVES AND PRESCRIBED MEDICATIONS

☐ PERFORM PRESUMPTIVE IMMUNOASSAY DRUG TEST ONLY

CONFIRMATION/DEFINITIVE LC-MS/MS TESTING

☐ CUSTOM PANEL ☐ CONFIRM ALL

☐ALCOHOL
- ☐Ethyl Glucuronide
- ☐Ethyl Sulfate

☐BARBITUATES
- ☐Butalbital
- ☐Pentobarbital
- ☐Phenobarbital
- ☐Secobarbital

☐BENZODIAZEPINES
- ☐7-aminoclonazepam
- ☐Alpha-hydroxyalprazolam
- ☐Alprazolam
- ☐Diazepam
- ☐Lorazepam
- ☐Nordiazepam
- ☐Oxazepam
- ☐Temazepam

☐CANNABINOIDS
- ☐JWH 18 4-OH Pentyl
- ☐JWH 250-4-OH Pentyl
- ☐JWH 73 3-OH Butyl
- ☐THC-COOH (THCA)

☐CATHINONES
- ☐Alpha PVP
- ☐MDPV
- ☐Methedrone
- ☐Pentedrone
- ☐Pentedrone Norephedrine

☐ECSTACY ANALOGS
- ☐MDA
- ☐MDEA
- ☐MDMA
- ☐Methylone

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

☐NICOTINE
- ☐Cotinine

☐OPIATES/OPIOIDS
- ☐6-MAM
- ☐Buprenorphine
- ☐Codeine
- ☐Desmethyltapentadol
- ☐EDDP
- ☐Fentanyl
- ☐Hydrocodone
- ☐Hydromorphone
- ☐Methadone
- ☐Morphine
- ☐Norbuprenorphine
- ☐Norfentanyl
- ☐Noroxycodone
- ☐Norpropoxyphene
- ☐O-Desmethyltramadol
- ☐Oxycodone
- ☐Oxymorphone
- ☐Propoxyphene
- ☐Tapentadol
- ☐Tramadol

☐OTHER PHARMACEUTICALS
- ☐Carbamazepine
- ☐Dextromethorphan
- ☐Gabapentin
- ☐Levetiracetam
- ☐Pregabalin

☐SEDATIVES
- ☐Zaleplon
- ☐Zolpidem
- ☐Zolpidem 6-Carboxylic

☐STIMULANTS
- ☐Amphetamine
- ☐Methamphetamine

☐TRICYCLICS/ANTIDEPRESSANTS
- ☐Amitriptyline
- ☐Desipramine
- ☐Desmethylcitalopram
- ☐Doxepin
- ☐Fluoxetine
- ☐Hydroxybupropion
- ☐Imipramine
- ☐Nortriptyline
- ☐Sertraline

☐UNSPECIFIED ILLICITS
- ☐7-Hydroxymitragynine
- ☐Benzoylecgonine
- ☐PCP

OTHER TESTS TO PERFORM

☐ SPECIMEN VALIDITY ☐ PREGNANCY (HCG)

PATIENT PRESCRIBED MEDICATIONS - Attach list if necessary

_____ _____ _____

PHYSICIAN AUTHORIZATION:

I authorize the laboratory test(s) as ordered, and affirm that each are both medically necessary and correspond to the patient's diagnosis as submitted to the laboratory for testing. I understand that each test I order is a billable event, and the patient's medical record(s) must clearly reflect my order.

Ordering Physician Signature (Required) Date

PATIENT AUTHORIZATION:

I voluntarily consent to the collection and testing of my specimen. I understand that I am responsible for all co-pays, deductibles, and amounts not covered by my insurance. I assign to Dynix Diagnostix, LLC all insurance payment(s) made for any laboratory services provided to me and direct same to represent me in any grievances or appeals process relating to the payment of these laboratory services. I consent to the release of any medical records necessary to process any insurance claim(s).

Patient Signature (Required) Date

T60000

Patient Name:_____ Collection Date:_____

DOB:_____ Collector's Name:_____