SURETOX
Results you can trust
241 Molnar Drive Suite A1
Elmwood Park NJ 07407
Tel: 201.791.7293 Fax: 866.425.4630

PRACTICE INFORMATION

Patient Name _____

Date of Collection _____

Patient Initials _____

Collector s Name _____

1 PATIENT INFORMATION (Required)

LAST NAME | FIRST NAME | M.I.

HOME ADDRESS | CITY | ST | ZIP | PHONE

DATE OF BIRTH | ○ M ○ F | HEIGHT (in) | WEIGHT (lbs)

2 BILLING INFO (Required)

○ Medicare ○ Medicaid ○ Workers' Compensation/ PIP (complete below) ○ Commercial ○ Client Billing ○ Self Pay

INSURANCE INFO _____

ADDITIONAL INFO (Required for all workers Compensation or if no Insurance card is attached)

CASE # _____ DATE OF INJURY/ACCIDENT _____ EMPLOYER/ATTORNEY/ADJUSTER NAME _____ PH. # _____

3 DIAGNOSIS CODES (ICD required to highest level of specificity)

○ TDM (additional primary diagnosis required for Worker's Compensation)
w= Z79.899 Long-term (current) use of other medications

1 _____.____ 2 _____.____ 3 _____.

4 POINT OF CARE DRUG TEST

Time Collected: _____ AM/PM

Date Collected: _____

Collected by: _____

Temp chk within 4 min of col and its between 90 - 100ºF or 32 - 38ºC ☐ Yes ☐ No

POCT SCREENING PANEL

Pos.	Neg.		Pos.	Neg.		Pos.	Neg.		Pos.	Neg.	
☐	☐	AMP	☐	☐	COC	☐	☐	MTD	☐	☐	PCP
☐	☐	BAR	☐	☐	MDMA	☐	☐	OPI	☐	☐	TCA
☐	☐	BZO	☐	☐	MET	☐	☐	OXY	☐	☐	THC
☐	NO POCT Performed.					☐	☐	PPX	☐	☐	BUP

5 TESTS TO BE ORDERED & PRESCRIBED MEDICATIONS (Presumptive screening and validity is performed on all URINE samples, if no POCT performed)

☐ MEDICATION LIST ATTACHED
☐ MEDICATIONS: _____ _____ _____
☐ CHECK BOX TO OPT OUT OF CONFIRMATION TESTING ON POSITIVE SCREEN RESULTS
☐ U001 URINE PRESUMPTIVE (SCREENING) TESTING ONLY.
☐ U010 URINE ALL DRUGS - Definitive (Confirmation) Drug test on ALL DRUGS from the table below, except as marked with *
☐ U011 URINE POSITIVE ONLY - Definitive (Confirmation) Drug Test on POSITIVE Presumptive (screening) results and prescribed medication
☐ U012 URINE PAIN MANAGEMENT PANEL - Definitive Drug Testing (AMPs, BARBS, BENZOS, ILLICITS, OPIOIDS) and prescribed medication
☐ U013 URINE SUBSTANCE ABUSE PANEL - Definitive Drug Testing (OPIOIDS, ILLICIT, BENZOS, AMPs/STIMULANTS, RELAXANTS) and prescribed medication
☐ N050 ORAL FLUID PANEL - Definitive Drug testing (AS MARKED IN YELLOW IN THE TABLE BELOW), except as marked with *

SELECT DRUGS/PROFILES FROM THE LIST BELOW TO BE CONFIRMED BY LC/MS.

ORDERED	PRESCRIBED	Drug or Profile	ORDERED	PRESCRIBED	Drug or Profile	ORDERED	PRESCRIBED	Drug or Profile	ORDERED	PRESCRIBED	Drug or Profile
		OPIOIDS			Sufentanil (Sufenta)			**TRICYCLIC ANTIDEPRESANTS**			**ALCOHOL (ETG/ETS)***
		Codeine (Tylenol III)			Pentazocine (Talwin)			Desipramine (Norpramin)			
		Morphine (MS Contin)			**BENZODIAZEPINES**			Doxepin (Sinequan)			**SSRI'S***
		Hydrocodone (Vicodin)			Alprazolam (Xanax) +			Imipramine (Tofranil)			Citalopram (Celexa) +
		Hydromorphone (Dilaudid)			Alpha-Oh-Alprazolam (metabolite)			Nortriptyline (Pamelor)			N-Desmethylcitalopram (metabolite)
		Oxycodone (Percocet)			Clonazepam (Klonopin) +			Trimipramine (Surmontil)			Duloxetine (Cymbalta)
		Oxymorphone (Opana)			7-Aminoclonazepam (metabolite)			Amitriptyline (Elavil)			Paroxetine (Paxil)
		SEMI-SYNTHETIC OPIOIDS			Diazepam (Valium) +			**ILLICITS**			Venlafaxine (Effexor) +
		Nalaxone (Narcan)			Nordiazepam (metabolite)			6-Mam (Heroin)			O-Desmethylvenlafaxine (metabolite)
		Buprenorphine + Norbuprenorphine			Oxazepam (Serax)			Benzoylecgonine (Cocaine)			**ANTITUSSIVES***
		(Butrans)			Temazepam (Restoril)			Methamphetamine			Dextromethorophan
		Buprenorphine + Norbuprenorphine +			Lorazepam (Ativan)			MDA (Adam)			**ANESTHETICS***
		Naloxone (Suboxone)			Flunitrazepam (Rohypnol)*			MDEA (Eve)			Ketamine (Special K) +
		Propoxyphene + Norpropoxyphene			Chlordiazepoxide (Librium)			MDMA (Ecstasy)			Norketamine (metabolite)
		Naltrexone (Revia)			Midazolam*			MDPV (Bath Salts)			**HALLUCINOGENS (ILLICIT)***
		Tapentadol (Nucynta)*			**RELAXANT / SLEEP**			Phencyclidine (Angel Dust)			LSD
		SYNTHETIC OPIOIDS			Carisoprodol (Soma			△ 9 THC			**SYNTHETIC CANNABINOIDS***
		Methadone (Dolophine) +			Cyclobenzaprine (Flexeril)			THC-COOH*			UR-144 +
		EDDP (metabolite)			Meprobamate (Equaril)			**AMPHETAMINES**			UR-144 5-OH-Pentyl (metabolite)
		Meperidine (Demerol)* +			Zaleplon (Sonata)			Amphetamine (Adderall)			XLR-11
		Normeperidine (metabolite)			Zolpidem (Ambien)			Methylphenidate (Ritalin)* +			**PSYCHOACTIVES***
		Fentanyl (Actiq, Duragesic) +			**BARBITURATES***			Ritalinic Acid (metabolite)*			Kratom (Mitragynine) +
		Norfentanyl (metabolite)			Butalbital (Fioricet)			**ANTICONVULSANT**			7-mitragynine (metabolite)
		Tramadol (Ultram)* +			Phenobarbital (Luminal)			Gabapentin (Neurontin)			
		O-Desmethyltramadol (metabolite)						Pregabalin (Lyrica)			

6 PATIENT AUTHORIZATION (Required)

Amitryptyline (Elavil)

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 Suretox to release the results of this testing to the treating authorized healthcare provider or facility. I hereby authorize my insurance benefits to be paid directly to Suretox for services I received. I understand that Suretox may be an out-of-network provider with my insurer. I also understand that in sometimes my insurance will send the payment directly to me. I agree to endorse the insurance check and submit it to Suretox immediately. Failure to send payment within 30 days of receipt could result in my account being turned over to collections and reported to the Credit Bureau.

Patient Signature: _____ Date: _____

7 PHYSICIAN SIGNATURE (Required)

I authorize the above ordered test(s)

Authorized Healthcare Provider Signature: _____ Date: _____

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