126 State Street
2nd Floor
Hackensack, NJ 07601
Phone: **973-542-2343** Fax: **201-621-6663**
CLIA No. 31D2109691

Provider: ____________

Location: ____________

TOXICOLOGY TEST REQUISITION

12/28/2018-3793363-408195-RDL1-00001201

RDL1

SPECIMEN COLLECTION

DATE: TIME: ☐ a.m. ☐ p.m.

☐ URINE ☐ ORAL FLUID

Collector Name: ____________

(A) PATIENT INFORMATION:

Last Name: ____________ First Name: ____________ MI: ____ Phone #: ____________

SSN: ____________ DOB: ____________ Gender: ☐ M ☐ F

Address: ____________ City: ____________ State: ____ Zip: ____________

Billing Information: ☐ **ATTACH INSURANCE INFORMATION (Including insurance company name, group #, ID #)**

☐ Insurance ☐ Medicare ☐ Medicaid ☐ Self-Pay ☐ PIP Date of Injury/Accident ________ ☐ Workers Comp Date of Injury/Accident ________

Insurance Company ____________ Insurance ID # ____________

DIAGNOSIS CODE:

☐ Z79.899 ☐ ____________
☐ Z79.891 ☐ ____________
☐ M54.2 ☐ ____________
☐ M54.5 ☐ ____________

(B) SCREENING – QUALITATIVE TESTING:

☐ Screen All w/ Validity, (Amphetamines, Barbiturates, Benzodiazepines, Cannabinoids, Cocaine Metabolite, Methadone, Opioids/Opiates, Oxycodone, PCP)

POCT SCREENING:

	Pos.	Neg.		Pos.	Neg.		Pos.	Neg.		Pos.	Neg.		Pos.	Neg.
AMP	☐	☐	BUP	☐	☐	MDMA	☐	☐	OXY	☐	☐	TCA	☐	☐
BAR	☐	☐	COCM	☐	☐	MTD	☐	☐	PCP	☐	☐	THC	☐	☐
BZO	☐	☐	MET	☐	☐	OPI	☐	☐	PPX	☐	☐			

CONFIRMATION – QUANTITATIVE TESTING:

☐ Confirm Positive Screening Results
☐ Confirm Prescribed Medications
☐ Confirm All
☐ **Saliva Confirmation Panel**

☐ Amphetamines
☐ Barbiturates
☐ Benzodiazepines
☐ GABA Inhibitors
☐ Illicits

☐ Opioids/Opiates
☐ Muscle Relaxants
☐ Sedatives
☐ Sleep Aids
☐ SSRi / SNRi

☐ THC
☐ Tricyclic Antidepressants
☐ Alcohol (EtG/EtS)

MEDICAL NECESSITY

☐ New patient baseline screening
☐ Long-term use of medications
☐ Medication Compliance Monitoring
☐ High-risk Group Patient Monitoring
Other: ____________

(C) REPORT PATIENT'S PRESCRIBED MEDICATIONS:

☐ Actiq	☐ Doxepin	☐ Meprobamate	☐ Oxycontin	☐ Tramadol
☐ Adderall	☐ Duragesic	☐ Methadone	☐ Oxymorphone	☐ Tylenol III, IV, V
☐ Alprazolam	☐ Fentanyl	☐ Methamphetamine	☐ Percocet	☐ Ultram
☐ Ambien	☐ Fioricet	☐ Morphine/MSIR	☐ Phenobarbital	☐ Valium
☐ Amitriptyline	☐ Flurazepam	☐ MS Contin	☐ Pregabalin	☐ Vicodin
☐ Amphetamine	☐ Gabapentin	☐ Naloxone	☐ Ritalin	☐ Xanax
☐ Buprenorphine	☐ Hydrocodone	☐ Neurontin	☐ Roxicodone	☐ Zohydro
☐ Carisoprodol	☐ Hydromorphone	☐ Norco	☐ Soma	☐ Zolpidem
☐ Clonazepam	☐ Klonopin	☐ Nortriptyline	☐ Suboxone	☐ **See Attached List**
☐ Codeine	☐ Lorazepam	☐ Nucynta	☐ Subutex	☐ ________
☐ Diazepam	☐ Lyrica	☐ Opana	☐ Tapentadol	☐ ________
☐ Dilaudid	☐ Meperidine	☐ Oxycodone	☐ Temazepam	☐ ________

(D) PATIENT AUTHORIZATION

I certify that I have voluntarily provided a fresh and unadulterated specimen for analytical testing. The information provided on this form and on the label affixed to the specimen cup is accurate. Also, I consent to the analysis of the specimen accompanying this form by the laboratory and I authorize Ridgewood Diagnostic Laboratory to release the results of this testing to the authorized testing healthcare provider or facility. This is an assignment of my rights to insurance benefits. I authorize any holder of my medical information and records to release to the health care financing administration and its agents, or any insurance company any information needed to determine these benefits or the benefits payable for the related services. If applicable, I hereby authorize, RIDGEWOOD DIAGNOSTIC LABORATORY, LLC to commence arbitration and/or litigation proceedings against the appropriate insurance carrier and/or initial a complaint to the Insurance Commissioner for any reason on my behalf in order for said provider to obtain payment for services furnished to me at RIDGEWOOD DIAGNOSTIC LABORATORY, LLC. I hereby authorize my insurance benefits to be paid directly to Ridgewood Diagnostic Laboratory for services I have received. I understand that Ridgewood Diagnostic Laboratory may be an out-of-network provider with my insurer. I also understand that sometimes my insurance will send the payment directly to me. I agree to endorse the insurance check and submit it to Ridgewood Diagnostic Laboratory 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.
I have read the ABN on the reverse. If Medicare denies the payment, I agree to pay for the identified test(s).

Patient Signature ____________ Date ____________

(E) PRACTITIONER AUTHORIZATION

Medicare and other payors only cover testing that is medically necessary. The undersigned affirms that the testing ordered on this requisition is medically necessary for the diagnosis and treatment of the patient for whom the testing has been ordered. I hereby authorize the above ordered laboratory test(s).

Ordering Physician Signature ____________ Date ____________

PLACE LABEL ON CUP

Patient Name: ____________
Date of Birth: ____________
Collection Date: ____________