OMNIHEALTH DIAGNOSTICS

OmniHealth Diagnostics
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URINE TOXICOLOGY

PATIENT - PLEASE PRINT LEGIBLY — REQUIRED

First Name | **Last Name**

Date of Birth | **Sex** ☐ Male ☐ Female | **Ethnicity** ☐African American ☐Asian ☐Caucasian ☐Jewish (Ashkenazi) ☐Hispanic ☐Portugese ☐Other:_____

Street Address | **Apt/Suite #**

City | **State** | **Postal Code**

ORDERING PHYSICIAN — REQUIRED

Office/Practice/Institution Name

Physician Name(s)

Street Address | **Apt/Suite #**

City | **State** | **Postal Code**

SPECIMEN INFORMATION — REQUIRED

Specimen Type | **Date of Collection** | **Time of Collection** : ☐ AM ☐ PM | **Collectors Initials**

Diagnosis (ICD-10) Codes

PATIENT INSURANCE — REQUIRED: ATTACH PATIENTS FACESHEET & COPY OF INSURANCE CARD

☐ **Private** ☐ **Self Pay** ☐ **Workers Comp** ☐ **Medicare** ☐ **Medicaid**

Insurance Company | **Policy Number**

MEDICATIONS — REQUIRED

☐ **MEDICATION LIST ATTACHED** ☐ **PATIENT REPORTS "NO MEDICATION"**

TEST REQUESTED — SELECT ONE (REQUIRED)

☐ DRUG SCREEN

6-Acetylmorphine
Amphetamine
Barbiturate
Benzodiazepine
Cannabinoid
Cocaine
EDDP Specific
Fentanyl
Opiate
Oxycodone
Phencyclidine
Specific Gravity
Oxidant
pH

REFLEX CONFIRMATION

☐ Amphetamines
☐ Benzodiazepines/Sedatives
☐ Illicits
☐ Opiates
☐ Oxycodones

☐ FULL CONFIRMATION

6-Acetylmorphone
7-Aminoclonazepam
Alpha-PVP
Alprazolam
Amitriptyline
Amphetamine
Benzoylecgonine
Buprenorphine
Carisoprodol
Citalopram
Clonazepam
Clozapine
Codeine
Cotinine
Cyclobenzaprine
Desipramine
Dextromethorphan
Dextrorphan
Diazepam
Diphenhydramine
Doxepin
EDDP
Fentanyl
Flunitrazepam
Fluoxetine
Flurazepam
Gabapentin
Hydrocodone
Hydromorphone
Imipramine
Ketamine
MDA
MDEA
MDMA
Meperidine
Mephedrone
Meprobamate
Methadone
Methamphetamine
Methylone
Methylphenidate
Morphine
Naloxone
Naltrexone
Norbuprenorphine
Norfentanyl
Norhydrocodone
Noroxycodone
Noroxymorphone
Nortriptyline
O-Desmethyl-cis-tramadol
Oxazepam
Oxycodone
Oxymorphone
Pentazocine
Phencyclidine
Phentermine
Pregabalin
Propoxyphene
Risperidone
Ritalinic Acid
Sertraline
Tapentadol
Temazepam
Tramadol
Trazodone
Triazolam
Zaleplon
Zolpidem
Zolpidem Phenyl-4-Carboxylic Acid

PHYSICIAN CONSENT & MEDICAL NECESSITY FOR TESTING — REQUIRED

I authorize **OmniHealth Diagnostics** and its affiliated labs to perform testing as directed by this test requisition form. I understand and hereby acknowledge that: When ordering test for which Medicare or Medicaid reimbursement will be sought, physicians should only order tests that are medically necessary for the diagnosis of the patient. Components may be billed separately per carrier policy. NOTE: The Office of Inspector General (OIG) takes the position that a physician who orders medically unnecessary test(s) for which Medicare reimbursement is claimed, maybe subject to civil penalties.

Physician Signature:_____ **Date:** _____

PATIENT ACKNOWLEDGEMENT & CONSENT — REQUIRED

I voluntarily consent to the collection and testing of my specimen and certify that the specimen identified on this form is my own and has not been adulterated in any manner. I certify that the information provided on this phone and on the specimen is accurate. I further authorize the laboratory to release the result of this testing to the ordering facility and/or my insurance company. I authorize my insurance company to pay in mail directly to **OmniHealth Diagnostics** and it's affiliated laboratories all benefits for payment of services rendered. I also authorize **OmniHealth Diagnostics** and it's affiliated laboratories to endorse any checks received on my behalf for payments of services provided. I hereby irrevocably assign to **OmniHealth Diagnostics** and it's affiliated laboratories all benefits under any policy of insurance indemnity agreement, or any collateral source as defined by statute for services provided. This assignment includes all rights to collect benefits directly from my insurance company and all rights to proceed against my insurance company in any action including legal suit, if for any reason my insurance company fails to make payment. This assignment also includes all rights to recover attorney fees and costs for such actions brought by the provider as my assignee.

Patient Signature: _____ **Date:** _____