



## DRUG TEST RESULT FORM SPECIMEN ID: TEST DATE:

DONOR INFORMATION (PATIENT BEING SCREENED)				
LAST NAME:		FIRST:		EMPLOYEE ID
DOB:				
COMPANY INFORMATION (COMPANY PERFORMING TEST)				
COMPANY:				
ADDRESS:				
	STATE:	ZIP	:	
CERTIFICATION				
I certify the specimen provided is my own and has not been substituted or adulterated. I further				
agree and grant permission for the testing of my specimen for drug metabolites.				
DONOR SIGNATURE: DATE:				:
I certify I collected the specimen provided by the aforementioned donor and that it is not substituted				
or adulterated to the best of my knowledge. Specimen temperature & color were acceptable.				
COLLECTOR SIGNATURE: DATE: _				:
DEVICE NAME: TEMPERATURE BETWEEN 90°-100°				
EXPIRATION: YES  NO				
ITEM #: LO	LOT #: NOTES:			
DRUG NAME	CUT-OFF	NEGATIVE	POSITIVE	NOT TESTED
Amphetamines (AMP)	1,000 ng/mL			
Barbiturates (BAR)	300 ng/mL			
Benzodiazepines (BZO)	300 ng/mL			
Buprenorphine (BUP)	10 ng/mL			
Cocaine (COC)	300 ng/mL			
Ecstasy (MDMA)	500 ng/mL			
Marijuana (THC)	50 ng/mL			
Methadone (MTD)	300 ng/mL			
Methamphetamines (MET)	1,000 ng/mL			
Opiates / Morphine (OPI/MOP)	300 ng/mL			
Oxycodone (OXY)	100 ng/mL			
Phencyclidine (PCP)	25 ng/mL			
Creatinine (CRE) (PH)	Specific Gravity (SG)	LOW NORMAL FROM	LOW NORMAL II	ICH LOW NORMAL BICL