Prorenata Laboratories, LLC

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Director: Steven Mahlen, Ph. D., D(ABMM) CLIA# 03D2147626

Facility: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Street Address: _____ Apt# _____ City: _____ State: _____ Zip: _____

Phone: _____ SSN: _____ D.O.B: _____ M ☐ F ☐

INSURANCE INFORMATION

Insurance Name: _____ I.D.: _____ Group: _____

ICD-10 CODES Circle all that apply	M54.5	M79.1	M79.7	Z79.891	Z79.899	Z91.19	Z91.14
ICD-10 CODES							

PATIENT CONSENT AND AUTHORIZATION:

I supplied accurate and true information with this form. If I supplied insurance information, I authorize payment of my insurance benefits directly to Prorenata Labs or their affiliates. I authorize Prorenata Labs or their affiliates to be my Designated Representative and to appeal any denial of health benefits. I understand Prorenata Labs or their affiliates may be out of network with my plan, and I accept responsibility for paying to Prorenata Labs or their affiliates any amounts my insurer determines are my responsibility after calculating deductibles, co-payments and co-insurance due under my policy. I understand I am legally responsible for sending Prorenata Labs or their affiliates any money received from my health insurance company for performance of this laboratory test. I also allow the release of medical information necessary to process this claim.

_____ _____
Patient Signature Date

PROVIDER AUTHORIZATION TO TEST:

I am authorized to order laboratory tests and hereby order the tests indicated below. I confirm these test(s) are medically necessary for the treatment of the patient. I supplied accurate and true information on this form. I am aware information has been supplied to the patient about drug testing and that the patient has consented to the testing through his/her signature on this form. I understand that it is my responsibility to document medical necessity for testing in the patient record and to provide a copy of the same to PRORENATA LABS or their affiliates upon request.

_____ _____
Physician Signature Date

Printed Physician Name _____

☐ **NO POCT Performed. Lab requested to perform screening levels.**

Time Collected: _____ AM / PM
Date Collected: _____ Collected by: _____
Temperature checked within 4 minutes of collection and is between 90 - 100 ºF or 32 - 38 ºC. Circle: (Yes) (No) (Not Measured)

SCREENING PANEL

○ **Presumptive Urine Drug Screen (UDS)**
Cannabis (THC) Amphetamine Cocaine Benzodiazepine Opiates Buprenorphine Barbiturates Oxycodone ETOH Methadone

○ **Validity Panel** Oxidants pH Specific Gravity Creatinine

URINE DRUG CONFIRMATION TEST MENU

○ **Full Urine Confirmation Panels**
(All Drug Classes & Metabolites)

○ **Opiates/Opioids**
- ☐ **Opiates**
  - Codeine
  - Morphine
  - Hydrocodone
  - Norhydrocodone
  - Hydromorphone
- ☐ **Propoxyphene**
  - Norpropoxyphene
- ☐ **Oxycodone**
  - Noroxycodone
  - Oxymorphone
- ☐ **Buprenorphine**
  - Norbuprenorphine
- ☐ **Fentanyl**
  - Norfentanyl
- ☐ **Tramadol**
- ☐ **Methadone**
  - EDDP
- ☐ **Tapentadol**

○ **Opiate Analogues**
- Meperidine
- Normeperidine

○ **THC-COOH**

○ **Stimulants**
- Amphetamine
- Methamphetamine
- ☐ **Test Only if Positive**
  - ☐ D/L Isomers
  - ☐ D-Meth Only
  - ☐ L-Meth Only

○ **Tricyclic Antidepressants**
- Nortriptyline
- Desipramine

○ **Benzodiazepines**
- Alprazolam
- Alpha-hydroxyalprazolam
- Diazepeam
  - Nordiazepeam
- Clonazepam
  - 7-aminoclonazepam
- Temazepam
- Oxazepam
- Lorazepam

○ **Muscle Relaxants**
- Carisoprodol
- Meprobamate

○ **Kratom**
- Mitragynine
- 7-OH-Mitragynine

○ **Illicits**
- ☐ **6-MAM (Heroin Metabolite)**
- ☐ **PCP**
- ☐ **Cocaine Metabolite**
  - Benzoylecgonine
- ☐ **Ketamine**
- ☐ **MDMA**
- ☐ **Synthetic Cannabinoids**
  - JWH-018 Metabolite
  - JWH-073 Metabolite

☐ **Medication List Attached**

Patient Medications:	Dose Date:

ABBREVIATED MEDICAL NECESSITY NOTES

REQUIRED ATTACHMENTS:

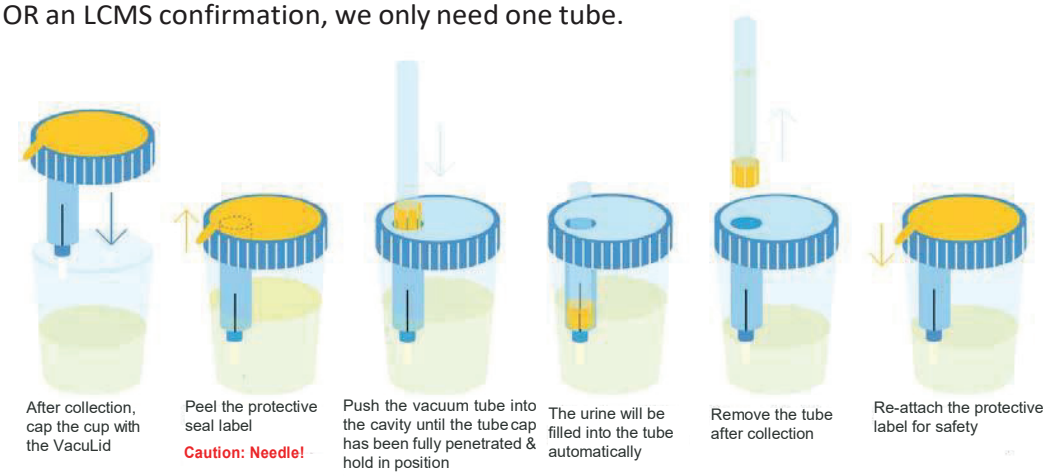
☐ Clear copy of front and back of insurance card
☐ Clear copy of driver's license
☐ SS # needed in box 1, if workers comp claim
☐ Copy of patient's demographics
☐ Prior authorization or accident form, if applicable

Urine Toxicology
Specimen Collection/Labeling
& Shipment

The Clinical Laboratory Improvement Act of 1988 established federal guidelines for proper specimen collections and labeling procedures which is adhered to by Prorenata Labs. If samples are received that do not meet the requirements below the samples can be rejected and new samples will need to be collected. If you have questions please contact the laboratory directly at 1-888-860-0014, Monday – Friday 8am to 5pm PST.

SPECIMEN COLLECTION/TRANSFER/LABELING PROCEDURE:

1. After collection of the sample by the patient you must transfer the sample into **TWO** vacutainer tubes provided. Vacutainer must have 12 milliliters each. If using the urine cup with the tube port, follow the diagram below. If only ordering one panel: either a screen OR an LCMS confirmation, we only need one tube.



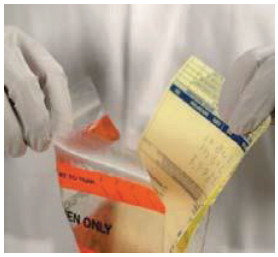
Label Tubes Immediately

- ***Must use provided lab label:*** ***Fill out, peel, stick to tube***
- ***Label tube in sight of patient***
- ***Put patients full name and date of birth***
- ***Date of collection & time***

SPECIMEN SHIPMENT:

1. UPS Shipments: After following the transfer/labeling steps above, place the samples inside the specimen biohazardous bag and apply the zip-lock seal. DO NOT send Specimen cups of any form as they were not designed for shipment and they will leak in transit which will result in a specimen rejection.

Place properly labeled specimens into biohazard sample bags.



Place specimen requisition, patient demographic sheet and insurance information into paperwork pouch on back of biohazard sample bag.

Place all samples into UPS Laboratory Pak and seal at the end of the day only. Place Pak into UPS box, put shipping label on box and place in designated pickup location.

During the summer months please use the insulated mailing packs and include 1 - 2 ice packs in every shipment.