

TEST RESULTS RECORD

SIDE 1

Test Reference Number _____ Name of Collector _____

COMPANY INFORMATION

Company Name _____ Phone _____ Fax _____

Address _____ City _____ State/Province _____ Zip/Postal Code _____

DONOR INFORMATION

Employee I.D. _____

Last Name _____ First Name _____

Type of Identification Provided: Driver's License Employee Photo I.D. Other _____Reason for test: Pre-employment Random Reasonable cause Post-accident Other _____

CERTIFICATION

I hereby certify that 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 and alcohol.

Donor signature _____ Date / Time _____

I hereby certify that I collected the specimen provided by the aforementioned Donor and that it was not substituted or adulterated to the best of my knowledge. The specimen temperature and color were acceptable.

Collector signature _____ Date / Time _____

Laboratory signature _____ Date / Time received _____

TEST RESULTS

Date Collected _____

Time Collected _____

Time Interpreted _____

Specimen Temperature:

 Normal: 90° to 100°F (32° to 38°C) Other _____

Note: Temperature must be read within four minutes of collection. Positive results must be confirmed by laboratory.

Drug Name	Symbol	Negative	Positive	Not Tested
Amphetamine	AMP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturate	BAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buprenorphine	BUP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benzodiazepine	BZO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	COC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	MDMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine	MET	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone	MTD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Opiates	OPI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oxycodone	OXY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phencyclidine	PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Propoxyphene	PPX	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tricyclic Antidepressants	TCA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	THC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Adulterants

	Normal	Abnormal	Not Tested
1. Creatinine (CR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Nitrite (NI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. pH (pH)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Specific gravity (SG)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Oxidants (OX)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Glutaraldehyde (GL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Alcohol

0% 0.04 0.08 0.20

1. Alcohol

Nicotine

Negative Positive Not Tested

1. Cotinine (COT) **IMPORTANT: Firmly tighten cup lid to avoid leakage.**

Results Window 1

1. If scanning a flat-panel cup, firmly tighten cup lid to avoid leakage.2. Place **SIDE 1** (this side) of Test Results Record face down on copier or scanner.

3. Place Side 1 of the device face down in the opening at right.

4. Copy or scan.

NOTE: If your device includes test strips on both sides of the device (Side 2), turn over this template and place SIDE 2 face down on copier or scanner to copy the results.

Cut out and remove this panel to copy or scan dip test or flat-panel cup results

Notes / Comments _____

TEST RESULTS RECORD

Test Reference Number _____

SIDE 2 *

DONOR INFORMATION

Employee I.D. _____

Last Name _____

First Name _____

CERTIFICATION

I, the Donor, hereby certify that 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 and alcohol.

Donor Signature _____

Date / Time _____

I, the Collector, hereby certify that I collected the specimen provided by the aforementioned Donor and that it was not substituted or adulterated to the best of my knowledge. The specimen temperature and color were acceptable.

Collector Signature _____

Date / Time _____

Laboratory Signature _____

Date / Time Received _____

TEST RESULTS

Drug Name	Symbol	Negative	Positive	Not Tested
Amphetamine	AMP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturate	BAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buprenorphine	BUP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benzodiazepine	BZO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine	COC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ecstasy	MDMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methamphetamine	MET	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone	MTD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Oxycodone	OXY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phencyclidine	PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Propoxyphene	PPX	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tricyclic Antidepressants	TCA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana	THC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Adulterants

	Normal	Abnormal	Not Tested
1. Creatinine (CR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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3. pH (pH)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Specific gravity (SG)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Oxidants (OX)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Glutaraldehyde (GL)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Alcohol

0% 0.04 0.08 0.20

1. Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Nicotine

Negative Positive Not Tested

1. Cotinine (COT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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* Use this side (SIDE 2) ONLY if test strips are included on both sides of the device.

IMPORTANT: Firmly tighten cup lid to avoid leakage.

Results Window 2

1. If scanning a flat-panel cup, firmly tighten cup lid to avoid leakage.

2. Place **SIDE 2** (this side) of Test Results Record face down on copier or scanner.

3. Place Side 2 of the device face down in the opening at right.

4. Copy or scan.

Notes / Comments _____

Cut out and remove this panel to copy or scan dip test or flat-panel cup results

Staple copy of completed SIDE 1 to this page