



bach diagnostics

passion, science, care

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PRACTICE INFORMATION: Practice Name, Address, Phone Number

Toxicology Laboratory Order Form

PATIENT INFORMATION:

Last Name _____ First Name _____ Middle Initial _____

Male Female Date of Birth _____ Social Security Number _____ Date of Incident _____ Phone Number _____

Street Address _____ City _____ State _____ Zip code _____

Insurance Type: Worker's Compensation Medi-Cal Medicare PPO Other (specify below)

Health Network Name _____ Member ID number _____ Group number _____

SPECIMEN INTAKE DETAILS:

Collector's Full Name: _____ Date Collected: _____ Time Collected: _____ AM / PM (circle one)

Temperature read within 4 minutes and is in range of 32.5 – 37.7°C (90.5 – 100°F)? Yes No N/A

DIAGNOSIS CODE:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Z51.81 – Encounter for therapeutic drug monitoring | <input type="checkbox"/> M51.36 – Lumbar intervertebral disc degeneration | <input type="checkbox"/> M54.12 – Cervical radiculopathy | <input type="checkbox"/> M54.15 – T/L radiculopathy |
| <input type="checkbox"/> Z79.891 – Long-term use of opiate analgesic | <input type="checkbox"/> M54.4 – Lumbago | <input type="checkbox"/> M50.30 – Cervical intervertebral disc degeneration | <input type="checkbox"/> M79.1 – Myalgia |
| <input type="checkbox"/> Z79.899 – Other long term drug therapy | <input type="checkbox"/> M54.14 – Thoracic radiculopathy | <input type="checkbox"/> M50.10 – Cervical intervertebral disc with radiculopathy | <input type="checkbox"/> M60.9 – Myositis |
| <input type="checkbox"/> G89.4 – Chronic pain syndrome | <input type="checkbox"/> M54.16 – Lumbar radiculopathy | <input type="checkbox"/> M54.17 – Lumbar-sacral radiculopathy | <input type="checkbox"/> M96.1 – Post laminectomy syndrome |
| <input type="checkbox"/> Other: | | | |

MEDICAL NECESSITY-CLINICAL FEATURES AND SYMPTOMS

Treatment for patients on chronic opioid therapy:

Low Risk Moderate Risk High Risk

Diagnosis and treatment for substance abuse:

0-30 days abstinent 31-90 days abstinent >90 days abstinent

TEST PANEL

Drug Panel – Definitive Drug Test by LCMS, Urine (see panel on backside)

Drug Panel – Definitive Drug Test by LCMS, Oral Fluids (see panel on backside)

MEDICATIONS

MEDICATIONS				POINT OF CARE RESULTS		
				TESTS	POS	NEG
<input type="checkbox"/> No drugs prescribed	<input type="checkbox"/> citalopram (Celexa)	<input type="checkbox"/> hydromorphone (Dilaudid)	<input type="checkbox"/> oxazepam (Serax)	Amphetamine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> alprazolam (Xanax)	<input type="checkbox"/> codeine (Tylenol 2/3)	<input type="checkbox"/> lorazepam (Ativan)	<input type="checkbox"/> oxycodone (Percet/Oxycontin)	Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> amitriptyline (Elavil)	<input type="checkbox"/> cyclobenzaprine (Flexeril)	<input type="checkbox"/> meprobamate (Miltown)	<input type="checkbox"/> pregabalin (Lyrica)	Benzodiazepines	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> amphetamine (Benzedrine)	<input type="checkbox"/> diazepam (Valium)	<input type="checkbox"/> meperidine (Demerol)	<input type="checkbox"/> propoxyphene (Darvocet)	Cocaine	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> buprenorphine (Buprenex)	<input type="checkbox"/> duloxetine (Cymbalta)	<input type="checkbox"/> methadone (Dolophine)	<input type="checkbox"/> sertraline (Zoloft)	Marijuana/THC	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> bupropion (Wellbutrin, Zyban)	<input type="checkbox"/> fentanyl (Duragesic)	<input type="checkbox"/> methamphetamine (Methedrine)	<input type="checkbox"/> sufentanil (Sufenta)	Opiates	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> butalbital (Fioricet)	<input type="checkbox"/> flunitrazepam (Rohypnol)	<input type="checkbox"/> midazolam (Versed)	<input type="checkbox"/> temazepam (Restoril)	Ecstasy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> carisoprodol (Soma)	<input type="checkbox"/> flurazepam (Dalmane)	<input type="checkbox"/> morphine (MS Contin)	<input type="checkbox"/> tramadol (Ultram)	Tricyclic Antidepressants	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> chlordiazepoxide (Librium)	<input type="checkbox"/> gabapentin (Neurontin)	<input type="checkbox"/> naloxone (Narca)	<input type="checkbox"/> zolpidem (Ambien)	Other:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> clonazepam (Klonopin)	<input type="checkbox"/> hydrocodone (Norco, Vicodin)	<input type="checkbox"/> naltrexone (Revia)	<input type="checkbox"/> Other:		<input type="checkbox"/>	<input type="checkbox"/>

AUTHORIZATIONS:

I certify that I have voluntarily provided a fresh, unadulterated urine specimen for analytical testing. The information provided on this form and on the label affixed to the specimen bottle is accurate. I authorize Bach Diagnostics to 1) release the results of this testing to the ordering provider, 2) bill and collect payment from my health insurance 3) bill me for any covered service deductible, copayment and/or coinsurance 4) obtain any information necessary from the ordering provider in an attempt to obtain payment from my insurance. I understand that Bach Diagnostics may be out-of-network with my health insurance company and if payment is remitted directly to me, I am responsible to Bach Diagnostics for the amount tendered.

Patient Signature: _____
Date: _____

IMPORTANT REQUIRED INFORMATION:

****If a physician signature is missing, there will be a delay in sample processing.****

The ordering physician or his/her authorized representative must sign his/her name and indicate that the test is ordered. The signature constitutes a certification that, with respects to tests reimbursed by Medicare or other third-party payers, the testing is medically necessary, and the results will be used in the management of the patient.

Physician/Representative Signature: _____
Date: _____

Name: _____ Name: _____ Name: _____ Name: _____

DOB: _____ DOB: _____ DOB: _____ DOB: _____

REQUIRED: Attach patient face sheet, as well as front and back copies of current insurance card(s).

Standard Drug Panel, Urine or Oral Fluids

6 MAM
7-amino clonazepam
Alpha-hydroxyalprazolam
Amphetamine
Benzoyllecgonine
Buprenorphine
Bupropion
Carbamazepine
Carisoprodol
Chlordiazepoxide
Codeine
Desmethylvenlafaxine
Dextromethorphan
Doxepin
EDDP
Fentanyl
Gabapentin
Hydrocodone
Hydromorphone
Ketamine
Lorazepam
MDMA
Meprobamate
Methamphetamine
Midazolam
Morphine
Naloxone
Naltrexone
Nordiazepam
Norfentanyl
Normeperidine
Normorphine
Nortriptyline
Oxcarbazepine
Oxazepam
Oxycodone
Oxymorphone
Paroxetine
PCP
Pregabalin
Propoxyphene
Sertraline
Tapentadol
Temazepam
Tramadol
Trazodone
Zolpidem

Full Drug Panel, Urine or Oral Fluids

11-9-THC
6- Acetylmorphine
7-Aminoclonazepam
7-Aminoflunitrazepam
Alpha-Hydroxyalprazolam
Alprazolam
Amitriptyline
Amobarbital
Amphetamine
Barbiturates
Buprenorphine
Bupropion
Butalbital
Carbamazepine
Carisoprodol
Citalopram
Clonazepam
Cocaine/Metabolite
Codeine
Cyclobenzaprine
Desipramine
Desmethy
Desmethylvenlafaxine
Dextromethorphan
Diazepam
Doxepin
EDDP
Ethyl Glucuronide
Fentanyl
Flunitrazepam
Flurazepam
Gabapentin
Hydrocodone
Hydromorphone
Imipramine
K2 Synthetic THC
Ketamine
Lorazepam
MDA
MDEA
MDMA
Meperidine
Meprobamate
Methadone
Methamphetamine
Methylphenidate
Midazolam
Mirtazapine
Morphine
Naloxone
Naltrexone
Norbuprenorphine
Nordiazepam
Norfentanyl
Norfluoxetine
Normeperidine
Norpropoxyphene
Nortriptyline
Oazepam
Oxcarbazepine
Oxycodone
Oxymorphone
Paroxetine

Pentazocine
Pentobarbital
Phencyclidine
Phenobarbital
Phentermine
Phenylpropanolamine
Pregabalin
Propoxyphene
Pseudoephedrine
Secobarbital
Sertraline
Sufentanil
Tapentadol
Temazepam
Tramadol
Trazodone
Triazolam
Venlafaxine
Zolpidem