Comprehensive Lab Services, LLC
2300 Austins Parkway Suite 400
Flint, MI 48507

Tel: 810-250-7573
Fax: 810-515-7570
Toll Free: 844-234-9758

URINE SPECIMEN INFORMATION

Time Collected: _____ AM / PM
Date Collected: _____
Collected By: _____
Temperature checked within 4 minutes of collection and is between
90 - 100˚F or 32 - 38˚C Yes ◯ No ◯ If no, actual temperature _____

ICD-9 CODE For Diagnosis, Symptom or Complaint

- ☐ **V58.69** Long term (Current) use of other medication
- ☐ **719.49** Pain in Joint, Multiple Sites
- ☐ **304.60** Other specified drug dependence, unspecified
- ☐ **300.02** Generalized Anxiety Disorder
- ☐ **304.90** Unspecified drug dependence
- ☐ **295.00** Simple type Schizophrenia unspecified state
- ☐ **296.02** BiPolar I Disorder, Single Maniac Episode, Moderate ☐ **Other** _____ ☐ **Other** _____
- ☐ **296.20** Major Depressive Affective Disorder Single Episode Unspecified Degree ☐ **Other** _____

POCT SCREENING

Pos.	Conf.		Pos.	Conf.		Pos.	Conf.		Pos.	Conf.	
☐	☐	AMP	☐	☐	COC	☐	☐	MTD	☐	☐	PCP
☐	☐	BAR	☐	☐	MDMA	☐	☐	OPI	☐	☐	TCA
☐	☐	BUP	☐	☐	MET	☐	☐	OXY	☐	☐	THC
☐	☐	BZO									

PANELS AND PROFILES [1, 2, 3] Please choose one option

- ◯ POCT Screening done - CLS Lab to perform Confirmation and Validity only
- ◯ No POCT Performed - CLS Lab to perform Screen, Confirm & Validity
- ◯ No POCT Performed - CLS Lab to perform Screen and Validity only

Please attach a copy of patient demographic sheet and insurance cards

Last Name	First	MI

Street Address 1	Street Address 2

City	State	ZIP

Social Security No.	Clinic - Name / Location

Gender	Date Of Birth (mm-dd-yy)	Phone No.
Unspecified/Unkown		

☐ Medicare ☐ Worker's Comp ☐ Private
☐ Medicaid ☐ Insurance ☐ Self Pay

Insurance Company:
Member / Insured ID No. Group ID No.
Insurance Company Address:

City	State	Zip

Date Of Injury: Claim No:
Claim Address:
Authorization / Referral No:

Patient Authorizaton / Patient Consent: I hereby authorize my insurance benefits to be paid directly to CLS for services I have received. I further consent to having these lab services performed. For billing questions, please call CLS @ **810-250-7573**.

Signature of Patient or Patient Representative and Relationship to Patient: _____

QUANTITATIVE TESTING

PLEASE MARK ALL PRESCRIBED MEDICATIONS AND ALL QUANTITATIVE TESTS

Ordered	Prescribed	Drug or Profile
☐		OPIOIDS (4)
☐	☐	CODEINE (Tylenol III)
	☐	MORPHINE
☐	☐	HYDROCODONE (Vicodin)
	☐	HYDROMORPHONE (Dilaudid)
☐	☐	OXYCODONE (Percocet)
	☐	OXYMORPHONE (Opana)
☐		SEMI-SYNTHETIC OPIOIDS
☐	☐	BUPRENORPHINE +
		NORBUPRENORPHINE (Buprenex) (5)
☐		SYNTHETIC OPIOIDS
☐	☐	METHADONE (Dolophine) + EDDP (metabolite) (6)
☐	☐	MEPERIDINE (Demerol) + NORMEPERIDINE (Metabolite)
☐	☐	FENTANYL (Actiq, Duragesic) + NORFENTANYL (Metabolite)
☐	☐	TRAMADOL (Ultram) + O-DESMETHYL-TRAMADOL (Metabolite)
☐	☐	PROPOXYPHENE (Darvocet) + NORPROPOXYPHENE (Metabolite)
☐	☐	TAPENTADOL (Nucynta)
☐		GABA INHIBITORS
☐	☐	GABAPENTIN (NEURONTIN, GRALISE)
☐	☐	PREGABALIN (LYRICA)
☐	☐	LEVETIRACETAM (KEPPRA)
☐		TRICYCLIC ANTIDEPRESSANTS (TCA)
☐	☐	AMITRIPTYLINE (ELAVIL)
	☐	NORTRIPTYLINE (PAMELOR)
☐	☐	DOXEPIN (APONAL, SINQUAN) +DESMETHYLDOXEPIN (METABOLITE)
☐	☐	IMIPRAMINE (TOFRANIL) + DESIPRAMINE (METABOLITE)
☐	☐	CLOMIPRAMINE (ANAFRANIL) + DESMETHYLCLOMIPRAMINE (METABOLITE)
☐		BARBITURATES
☐	☐	BUTALBITAL (FIORICET, FIORINAL)
☐	☐	PHENOBARBITAL (LUMINAL)

Ordered	Prescribed	Drug or Profile
☐		BENZODIAZEPINES (7)
☐	☐	ALPRAZOLAM (Xanax) + a-OH-ALPRAZOLAM (Metabolite)
☐	☐	7-AMINOCLONAZEPAM (Klonopin Metabolite)
☐	☐	DIAZEPAM (Valium) + NORDIAZEPAM (Metabolite)
☐	☐	OXAZEPAM (Serax)
		TEMAZEPAM (Restoril)
☐	☐	LORAZEPAM (Ativan)
☐		ILLICITS
☐		6-MAM (Heroin)
☐		BENZOYLECGONINE (Cocaine) (11)
☐		METHAMPHETAMINE (10)
☐		MDMA (Ecstasy) (12)
☐		PHENCYCLIDINE (Angel Dust) (13)
☐	☐	THC (Marijuana Metabolite) (Medical Marijuana) (9)
☐		NICOTINE METABOLITE
☐	☐	COTININE (Metabolite of Nicotine)
☐		RELAXANT / SLEEP AIDS
☐	☐	CARISOPRODOL (Soma)
☐	☐	MEPROBAMATE (Equanil)
☐	☐	CYCLOBENZAPRINE (Flexeril, Amrix, Fexmid)
☐		STIMULANTS
☐	☐	AMPHETAMINE (Adderal) (8)
☐	☐	METHYLPHENIDATE (RITALIN)
☐		SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRi)
☐	☐	CITALOPRAM (CELEXA, LEXAPRO) + DESMETHYLCITALOPRAM (METABOLITE)
☐	☐	FLUOXETINE (PROZAC) + NORFLUOXETINE (METABOLITE)
☐	☐	PAROXETINE (PAXIL)
☐	☐	SERTRALINE (ZOLOFT)
☐	☐	TRAZODONE (OLEPTRO, DESYREL)
☐		SELECTIVE NEUREPINEPHRINE REUPTAKE INHIBITORS (SNRi)
☐	☐	VENLAFAXINE (EFFEXOR)
☐	☐	O-DESMETHYLVENLAFAXINE (PRISTIQ)

ADDITIONAL TESTS, PANELS AND COMMENTS

Medicare and other payors only cover testing that is medically necessary. The undersigned affirms that the testing ordered on this requisition is medically necessary for the diagnosis and treatment of the patient for whom the testing has been ordered.

I hereby authorize the above ordered laboratory test(s). Physician Name_____ **Physician Signature** : _____ **Date:**_____

Email: info@compls.com
Web: www.compls.com

Reset Form

Print Req. Form