

Drug Screen Result Form

COMPANY INFORMATION:
NEW HAVEN ASSISTED LIVING & MEMORY CARE

Address:
City:
State:
Zip:
Phone:

DONOR INFORMATION:
NAME:

REASON FOR TEST:
☐ Pre-Employment
☐ Random
☐ On the Job Injury

ARRIVAL TIME: _____ DEPARTURE TIME: _____

TO BE COMPLETED BY DONOR:

I certify that the specimen provided is my own and has not been substituted or altered. I further agree and grant permission for the testing of my urine specimen for drug metabolites. I voluntarily consent to this testing.

Print Donor Name

Donor Signature

Date

TO BE COMPLETED BY SCREENING PERSONNEL:

DRUG NAME	DEVICE CODE	CUT-OFF LEVEL	NEGATIVE	POSITIVE	NOT TESTED
COCAINE	COC	300ng/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MARIJUANA	THC	50ng/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OPIATES	OPI	2000ng/m	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
METH-AMPHETAMINE	MET	1000ng/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
AMPHETAMINE	AMP	1000ng/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PROPOXYPHENE	PPX	300ng/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BENZODIAZEPINES	BZO	300ng/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BARBITURATES	BAR	300ng/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MDMA (Ecstasy)	MDMA	500ng/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OXYCODONE	OXY	100ng/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MORPHINE	MOP	300ng/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BUPRENORPHINE	BUP	10ng/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
METHADONE	MTD	300ng/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PHENCYCLIDINE	PCP	25ng/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EDDP (Methadone Metabolites)	EDDP	300ng/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TRICYCLIC ANTIDEPRESSANTS	TCA	1,000ng/ml	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specimen Temperature: (90-100°F) In Range Other: _____

I certify that I collected the specimen provided by the Donor and that it was not substituted or adulterated to the best of my knowledge. The specimen temperature and color were acceptable. I have verified the donor identity by review of the donor's picture ID or by employer or test requestor verification.

Print Collector Name

Collector Signature

Date