CENTRAL CLINICAL LABS

6858 W. ARCHER AVE. • CHICAGO, IL 60638
TEL. (773) 788-1577 • FAX (773) 788-1579

SPECIMEN INFORMATION

STAT	DATE COLLECTED	TIME COLLECTED : ☐ A.M. ☐ P.M.	FOR LAB USE: DATE RECEIVED

PATIENT LAST NAME (Please Print)	FIRST NAME (Please Print)

SEX (M / F)	DATE OF BIRTH (M / D / Y)	PATIENT'S RELATIONSHIP TO INSURED ☐ SELF ☐ DEPENDENT ☐ SPOUSE ☐ OTHER	BILL TO: ☐ PATIENT ☐ CLIENT	PATIENT I.D.

BILLING ADDRESS			APT. NO.
CITY	STATE	ZIP	TEL. NO. (9-5)
MEDICAID NUMBER		MEDICARE NUMBER	SUFFIX

BILLING INFORMATION AND ABN

NAME OF INSURANCE / HMO / PPO

IF REQUIRED, ATTACH COMPLETED SIGNED FORM

CERTIFICATE OR I.D. No.

INSURANCE CLAIM MAILING ADDRESS

CITY	STATE	ZIP

PATIENT - READ AND SIGN

MEDICAL RELEASE: I authorize the release of any medical information to process this claim and request payment of benefits to Central Clinical Laboratory and shall be personally responsible for any unpaid balance.

IF HIV TEST IS ORDERED, I AGREE TO BE TESTED.

PATIENT OR AUTHORIZED PERSON SIGNATURE (Must)

X

ORDERING PHYSICIAN INFORMATION

DIAGNOSIS	DIAGNOSIS	DIAGNOSIS
(ICD-9)	(ICD-9)	(ICD-9)

PHYSICIAN OR AUTHORIZED PERSON SIGNATURE (Must)*

X

SPACE BELOW FOR ADDITIONAL INSTRUCTIONS / TESTS. SOME TESTS COVERED BY MEDICARE HAVE LIMITED COVERAGE (See ABN)

CURRENT MEDICATION

(COMPLETE FOR ALL RELEVANT CONTROLLED MEDICATIONS, DATE OF LAST DOSE IS THE LAST TIME MEDICATION WAS INGESTED. IF MEDICATION IS TAKEN AS NEEDED, SPECIFY PRN BY CHECKING THE BOX)

Prescription	Dose	Frequency	Date of Last Dose (optional)	PRN	Prescription	Dose	Frequency	Date of Last Dose (optional)	PRN
Morphine					Ultram®/Tramadol				
Dolophine®/Methadone					Valium®/Diazepam				
Flexerit®/Cyclobenzaprine					Flexerit®/Cyclobenzaprine				
Klonopin®/Clonazepam					Xanax®/Alprazolam				
Lyrica®/Pregabillin					____________				
Neurontin®/Gabapentin					____________				
Norco®/Vicodin®/Hydrocodone					____________				
Perocet®/Oxycontin®/Oxycodone					____________				
Roxicodone®/Oxycodone					____________				
Suboxone®/Oxycodone					____________				
Soma®/Carisoprodol					____________				

POINT OF CARE TEST RESULTS

	Code	DRUG NAME	NEG	PRESUMPTIVE POSITIVE
☐	82145	Amphetamine (AMP)	☐	☐
☐	82205	Barbiturates (BAR)	☐	☐
☐	80154	Benzodiazepines (BZO)	☐	☐
		Buprenorphine (BUP)	☐	☐
☐	82520	Cocaine (COC)	☐	☐
☐	82542	Marijuana (THC)	☐	☐
☐	83840	Methadone (MTD)	☐	☐
☐	82055	ETG		

	Code	DRUG NAME	NEG	PRESUMPTIVE POSITIVE
☐	82145	Methamphetamine (mAMP)	☐	☐
		Ecstasy (MDMA)	☐	☐
☐	83925	Opiate (OPI/MOP)	☐	☐
		Oxycodone (OXY)	☐	☐
☐	83992	Phencyclidine (PCP)	☐	☐
		Propoxyphene (PPX)	☐	☐
		Tricyclic Antidepressants (TCA)	☐	☐
		Other____________	☐	☐

☐ PRE-MEDICATION SCREEN

LAB USE
☐ G-0431
☐ 80101 X____________

PHYSICIAN USE
☐ G-0434
☐ 80104 X____________

Form No. 15121

WHITE - LAB / YELLOW - AMS / PINK - CLIENT