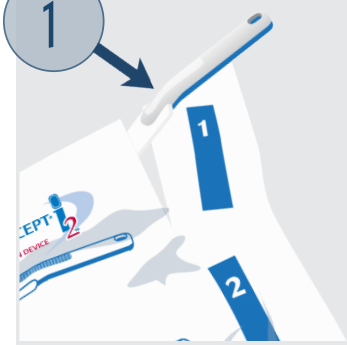
How to Collect Oral Fluid

For Therapeutic Drug Monitoring

Intercept® i2™ Collection Device

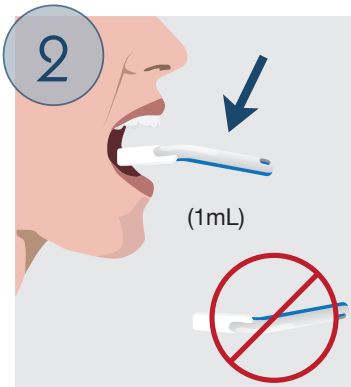
To ensure proper collection, check the patient's mouth prior to collecting the sample. If the patient has had anything in his or her mouth within the past 10 minutes, wait 10 minutes prior to collecting the sample.

1



Check the expiration date and remove the collection pad from the pouch

2

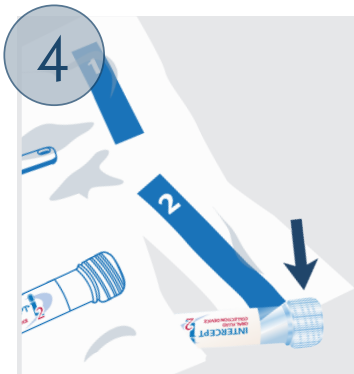


Without touching the pad, insert the pad under the tongue with white side up

3

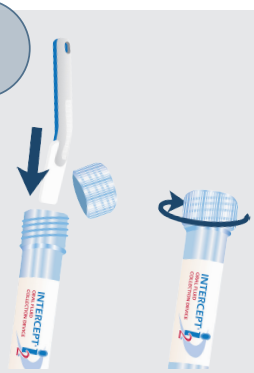
Hold the pad under the tongue until the indicator turns blue - 3 minutes on average

4



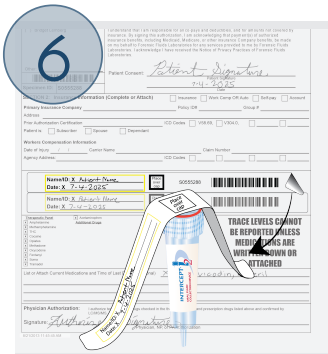
Remove the specimen vial from the collection device package

5



Unscrew the cap and place the collection device pad down in the vial - replace cap tightly

6



Remove a label from the completed requisition form* and seal the tube

7

Insert sealed tube and completed form into specimen bag and seal

8

Use the prepaid UPS shipping bags to send samples to FFL

Questions? Call us at 866.492.2517

*See reverse side for requisition form instructions

forensicfluids™ laboratories

T-00031-3-022222

How to Fill Out a Requisition Form

Please write legibly on the requisition form.

Completed by patient | **Completed by office staff**

1. Patient Information
Please complete patient information box. REQUIRED

2. Patient Consent
Patient consent is REQUIRED for processing.

3 a. Collection Date and Time:
Write in the date and time the specimen was collected.

3 b. Insurance Info.
Please include all insurance information for billing purposes. If your patient's demographic sheet includes all billing information listed in section 2, only the ICD code(s) are required. REQUIRED

4. List of Current Medications
Please fill in the dosages and the time of last dose on the requisition or attach a medication list.

5. Seals For Sample
Please instruct the donor to write his or her name and date on both seals. These should be used only to seal specimen tubes (one strip per tube please. The second strip is backup).

6. Selection of Tests
The requisition form is be populated with drug/ medications based on your existing service agreement. Simply X the boxes of the medically necessary tests by patient to order the test. REQUIRED

Forensic Fluids Laboratories

225 Parsons Street Kalamazoo, MI 49007 • (866) 492-2517 phone • (269) 492-7704 fax

Account Information:
Forensic Fluids Demo Account - Therapeutic
225 Parsons St
Kalamazoo, MI 49007
Phone: (269)492-7700
Account#: 13031197

1.

Patient Information (Complete or Attach)

Name: _____

Street: _____

City: _____ State: _____ ZIP: _____

SSN: _____ Phone: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

2.

I understand that I am responsible for all co-pays and deductibles, and for amounts not covered by insurance. By signing this authorization, I am acknowledging that payment(s) of authorized insurance benefits, including Medicaid, Medicare, or other insurance Company benefits, be made on my behalf to Forensic Fluids Laboratories for any services provided to me by Forensic Fluids Laboratories. I understand that Forensic Fluids Laboratories Notice of Privacy Practices is available upon request.

Patient Consent: _____
Patient Signature:

3a.

Collection Date: _____ Collection Time: _____

☐ **SELF PAY PATIENT** ☐ **ATTACHED COPY OF INSURANCE CARD**

Other: _____

3b.

ICD Codes ☐ Z79.899 Other long term (current) drug therapy ☐ Z79.891 Long term (current) use of opiate analgesic ☐ _____

Specimen ID: S4027103

List or Attach Current Medications with Dosage and Time of Last Dose:

- Current prescribed medications must be listed to ensure reporting to cutoff levels

4.

Medication	Dosage	Time of Last Dose

5.

Name/ID: X _____
Date: X _____
Place over cap
S4027103

Name/ID: X _____
Date: X _____
Place over cap
S4027103

Please select tests medically necessary

6.

Screen & Confirm	Screen Only		
☐	☐	**Amphetamine**	Amphetamine,MDA
☐	☐	**Methamphetamine**	Methamphetamine,Amphetamine,Ephedrine,MDMA
☐	☐	**THC (Conf if pos)**	THC
☐	☐	**Cocaine**	Cocaine,Benzoylecgonine (BZE),Ecgonine Methyl Ester (EME),Cocaethylene
☐	☐	**Opiates**	6-Acetylmorphine (6MAM),Codeine,Hydrocodone,Hydromorphone,Morphine,Norhydrocodone
☐	☐	**Methadone**	Methadone,EDDP
☐	☐	**Oxycodone**	Oxycodone,Oxymorphone,Noroxycodone
☐	☐	**Tramadol**	Tramadol (Ultram)
☐	☐	**Fentanyl**	Fentanyl,Norfentanyl
☐	☐	**Carisprodol(Soma) (Conf if pos)**	Carisprodol(Soma)
☐		**Acetaminophen (Confirm)**	Acetaminophen

7.

Signature / Provider Authorization (I authorize testing for the drugs selected / ordered above and prescription drugs listed above or attached): _____
Physician, NP, or PA Authorization

White Copy - Lab **Yellow Copy - Client**

7. Physician Authorization
Provider signature is recommended on all requisition forms.