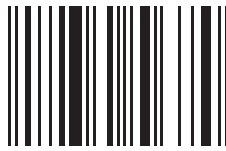


# Western Diagnostic Pathology

74 McCoy St, Myaree WA 6154  
 24 hour Support Hotline 0407 682 522  
 Email: aod.support@maynegroup.com



010001

WDP USE ONLY	
Dr Code	DTO
Acc Code	DTO
Panel Code	\$GC

CLIENT / EMPLOYER	
Name:	_____
Account:	_____
Address:	_____
Phone/Fax:	_____

REFERRING PHYSICIAN / MRO	
Name:	_____
Address:	_____
Phone/Fax:	_____

## AccuSign®

FOR USE IN URINE  
DRUGS OF ABUSE TESTING

PO Box 109, Inglewood WA 6932  
PO Box 5066, Whangarei 0101, NZ

TESTING OFFICER
Collection Site Name: _____
Collection Site Address: _____
Collection Site Phone: _____
Reason for Test: _____
<input type="radio"/> Pre-Employment <input type="radio"/> Random <input type="radio"/> Return to Duty <input type="radio"/> Reasonable Cause/Suspicion <input type="radio"/> Post-Accident <input type="radio"/> Periodic <input type="radio"/> Other _____

DONOR AFFIDAVIT / INFORMATION
Name: _____
Date of Birth: _____ Sex: <input type="radio"/> M <input type="radio"/> F I.D. _____
Medication Taken (Prescription or Non-Prescription) in the last 14 days: _____
I certify that I provided my urine specimen to the Testing Officer, that I have not adulterated it in any manner and the information provided on this form and on the label affixed to the specimen bottle is true and correct. I understand that I have the right to request that the urine sample be split and a portion of the sample sent for GC/MS testing.
Print Name: _____
Signature of Donor: _____ Date: _____

TESTING OFFICER
Donor ID Verified: <input type="radio"/> Photo ID <input type="radio"/> Employee Representative ID
Split Sample Collected: <input type="radio"/> Yes <input type="radio"/> No
<b>Sample Information:</b>
Record of Temperature: <input type="radio"/> Yes <input type="radio"/> No If Yes - Specimen Temperature within range 33-38 C: <input type="radio"/> Yes <input type="radio"/> No
Adulteration Test: <input type="radio"/> Yes <input type="radio"/> No
Comments: _____
<b>Test Requested:</b>
<input type="radio"/> Cannabinoid, THC <input type="radio"/> Amphetamine, AMP <input type="radio"/> Opiates, OPI <input type="radio"/> Methadone, MTD <input type="radio"/> Other _____ <input type="radio"/> Benzodiazepine, BZO <input type="radio"/> Methamphetamine, MET <input type="radio"/> Cocaine, COC <input type="radio"/> Other _____ <input type="radio"/> Other _____
I have received the specimen from the Donor and verified that the ID numbers on the form and all the specimen containers match. I have performed the initial test using a immunoassay at the SAMHSA cut-off levels, where applicable. I verify that the screening kit is within the expiration date and the internal controls performed within specification.
Initial Screen Results: <input type="radio"/> All Negative
Non-Negative Screen Results:
<input type="radio"/> Cannabinoid, THC <input type="radio"/> Amphetamine, AMP <input type="radio"/> Opiates, OPI <input type="radio"/> Methadone, MTD <input type="radio"/> Other _____ <input type="radio"/> Benzodiazepine, BZO <input type="radio"/> Methamphetamine, MET <input type="radio"/> Cocaine, COC <input type="radio"/> Other _____ <input type="radio"/> Other _____
<b>Confirmatory Testing Requested:</b>
<input type="radio"/> Cannabinoid, THC <input type="radio"/> Amphetamine, AMP <input type="radio"/> Opiates, OPI <input type="radio"/> Methadone, MTD <input type="radio"/> Other _____ <input type="radio"/> Benzodiazepine, BZO <input type="radio"/> Methamphetamine, MET <input type="radio"/> Cocaine, COC <input type="radio"/> Other _____ <input type="radio"/> Other _____

Print Name	Signature of Testing Officer	Date
I have received the split specimen from the initial test site and verified that the ID number on this form and the specimen container match and the tamper evident seal is intact.		
Print Name	Signature of Laboratory	Date

Prepaid GC/MS BioSafe Bag Barcode No.
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Drugs of Abuse Chain of Custody Form