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PAIN MANAGEMENT REQUISITION

SPECIMEN COLLECTION

Date: ___ / ___ / ___ Time: ___ : ___ ☐ am ☐ pm

PHYSICIAN'S INFO

☐ Call results to: ( ) ____________

☐ Fax results to: ( ) ____________

Signature ____________

☐ Diagnostic Codes: ____________

PATIENT INFORMATION

Last Name: ____________ First Name ____________

M.I. ______ Gender ☐F ☐M DOB ___ / ___ / ___ Phone: ( ) ____________

Address: ____________ SSN: ___ – ___ – ___

City: ____________ State: ______ Zip: ______ Pt. ID ____________

BILLING INFO

Insurance Co. Name: ____________ Subscriber Member # ____________ Group # ______

Physician's Provider ____________

Insurance Address ____________ City: ____________ State: ______ Zip: ______

☐ Bill Patient ☐ Bill Client

COMMENTS

INDICATE CURRENT MEDICATIONS

☐ ACTIQ	☐ CHLORDIAZEPOXIDE	☐ ELAVIL	☐ LIDODERM	☐ MILTOWN	☐ OXYMORPHONE	☐ ROXICODONE	☐ TYLENOL #5
☐ ADDERALL	☐ CLONAZEPAM	☐ ENDOCET	☐ LIPITOR	☐ MOBIC	☐ PAXIL	☐ SATIVEX	☐ TYLOX
☐ ALBUTEROL	☐ CLONIDINE	☐ EQUANIL	☐ LORAZEPAM	☐ MORPHINE	☐ PERCOCET	☐ SERAX	☐ ULTRACET
☐ ALPRAZOLAM	☐ CODEINE	☐ FENTANYL	☐ LORCET	☐ MSCONTIN	☐ PERCODAN	☐ SKELAXIN	☐ ULTRAM
☐ AMITRIPTYLINE	☐ CYMBALTA	☐ FLEXERIL	☐ LORTAB	☐ MSIR	☐ PERCOLONE	☐ SOMA	☐ VALIUM
☐ AMPHETAMINE	☐ DARVOCET	☐ FIORICET	☐ LUNESTA	☐ NEMBUTAL	☐ PHENERGAN	☐ SUBOXONE	☐ VERSED
☐ ATENOLOL	☐ DARVON	☐ FIORINAL	☐ LYRICA	☐ NEURONTIN	☐ PHENOBARBITAL	☐ SUBUTEX	☐ ViCODIN
☐ ATIVAN	☐ DEMEROL	☐ GABAPENTIN	☐ MARINOL	☐ NEXIUM	☐ PREGABALIN	☐ TEMAZEPAM	☐ ViCOPROFEN
☐ AVINZA	☐ DESOXYNE	☐ HALCION	☐ MAXIDONE	☐ NORCO	☐ PREVACID	☐ TOPAMAX	☐ VYVANSE
☐ BACLOFEN	☐ DEXEDRINE	☐ HYCODAN	☐ MEPROBAMATE	☐ NUCYNTA	☐ PRILOSEC	☐ TRAMADOL	☐ WELLBUTRIN
☐ BUPRENEX	☐ DIAZEPAM	☐ HYDROCODONE	☐ MEPROSPAN	☐ NUMORPHAN	☐ PROPOXYPHENE	☐ TRANXENE	☐ XANAX
☐ BUPRENORPHINE	☐ DILAUDID	☐ HYDROMORPHONE	☐ METFORMIN	☐ OPANA	☐ PROZAC	☐ TRAZADONE	☐ ZYDONE
☐ BUTALBITAL	☐ DOLOPHINE	☐ KADIAN	☐ METHADONE	☐ ORAMORPHAN	☐ RESTORIL	☐ TRIAZOLAM	☐ OTHER(S)
☐ CARISOPRODOL	☐ DURAGESIC	☐ KLONOPIN	☐ METHYLPHENIDATE	☐ OXAZEPAM	☐ RITALIN	☐ TUSSIONEX	☐
☐ CELEBREX	☐ DURAMORPH	☐ LEXAPRO	☐ METOPROLOL	☐ OXYCODONE	☐ ROBAXIN	☐ TYLENOL #3	☐
☐ CELEXA	☐ EFFEXOR	☐ LIBRIUM	☐ MIDAZOLAM	☐ OXYCONTIN	☐ ROXANOL	☐ TYLENOL #4	☐

PATIENT AUTORIZATION

I authorize the collection of this specimen for the purpose of analytical testing by Accu Reference and release of results to my treating physician and staff. I authorize Accu Reference and or its designees to obtain insurance and billing information and release of such information as necessary to determine and collect benefits. I understand I am financially responsible for payments should Insurance be denied, partially paid, or co-payments required.

Patient Siganture: ____________ **INTIALS** ____________ ___ / ___ / ___

MONTH DAY YEAR

COLLECTOR Have patient initial and date the specimen seal and affix over the top of the urin container and down the sides.
Place specimen into shipping bag for shipment to Accu Reference.

Name: ____________

Date: ___ / ___ / ___ Initials: ____________

LABORATORY COPY