Drug Screen Confirmation Test

PHYSIOHEALTH CAIRNS

As part of your pre-employment, you are required to attend our Pathology Collection Centre **immediately** to provide a urine sample for the purposes of a confirmatory drug test. This test is a requirement of Bodycare's pre-employment process, delivered on behalf of your potential employer.

Preparing for Your Test

- Please contact the Collection Centre to advise that you need to have a confirmatory drug test performed **immediately** after a non-negative instant drug test.
- You **MUST** attend the pathology Collection Centre **immediately** to provide a confirmatory sample. Failure to attend your lab-based drug test confirmation immediately may result in the assessment being incomplete, which may impact your application. If you are unable to attend immediately, please contact Bodycare to advise.
- Please advise the Collection Centre that you are attending a pre-employment drug test for Bodycare.
- It is essential that you bring your referral document to the Collection Centre.
- You are not required to pay for the test on the day (payment is included as part of your final pre-employment fee).
- Please avoid any caffeinated drinks and please do not drink more than one glass (250 ml) of water two hours prior to your appointment. The consumption of too much water may dilute your sample. In the instance of this occurring, we will require you to be re-tested.

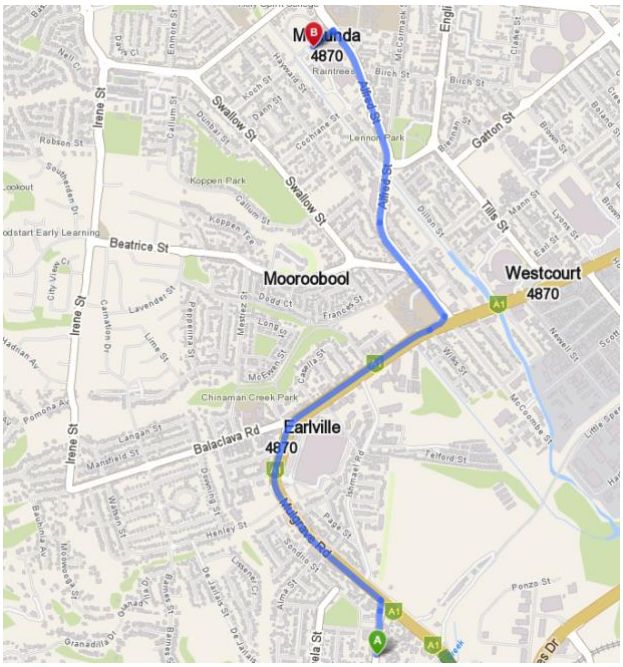
Location

QML Pathology

Raintrees Shopping Centre,
Tenancy 21b, Alfred Street,
Manunda, QLD 4870

Mon – Fri 07:45 – 12:45,
Sat 07:00 – 12:00

07 4032 0806



Urine Drugs of Abuse Request and Chain-of-Custody Form

All details must be completed to comply with Australian Standard AS/NZ 4308:2008 QML Pathology.

DONOR INFORMATION

Surname: _____ Given Name: _____ Date of Birth: ____ / ____ / ____ M / F (Please Circle)

Address: _____ Contact Phone: _____

Identity of Donor Verified by: ☐ Photo ID only ID Type: _____ ID Number: _____

REQUESTING AUTHORITY

Company: **Body Care Workplace Solutions** Company Collection Site: _____ QML Account/Doctor Code **BBW2M**

Nominated Representative: _____ Contact Phone: _____

Reason for testing: ☑ Pre-Employment ☐ Court related ☐ Rehabilitation ☐ Medical ☐ Other: _____

Employment related Testing AS/NZS 4308:2008	Commercial / Medical Testing / Rehabilitation	Other Testing
☑ Laboratory Urine Drug Screen (DS4) ☐ + Alcohol (+ETH)	☐ Medical Urine Drug (DS2) ☐ + Alcohol (DSA)	☐ Urine Salbutamol (SBL)
☐ Urine Drug Confirmation (Specify Class):_____	☐ Urine Drug Screen Rehab (DRP) ☐ + Alcohol (+ALC)	☐ Urine Synthetic Cannabinoids (SYC)
☐ Laboratory Alcohol Screen only (DSE)	☐ Medical Urine Alcohol only (UAQ)	☐ Urine Drug (specify drug):_____ (UDC)
☐ Instant Urine Drug Screen (DS8) ☐ + Breath Alcohol (+BET)	☐ Urine Ethyl Glucuronide (ETG)	☐ Serum Carbohydrate Deficient Transferrin (CDR)

DONOR CERTIFICATION

I certify that the specimens accompanying this form are my own and were provided by me to the collector. Further, I certify that the specimen containers were sealed with tamper-evident seals in my presence and that the information provided on this form and on the labels, is correct. I consent to the analysis of the specimens for the compounds included in the requested tests and the release of results to the requesting officer.

Donor Signature: _____ **Date:** ____ / ____ / ____

COLLECTOR CERTIFICATION

HEALIUS COLLECTOR USE ONLY	AFFIX BARCODE	Clinic:	BC **5300**	Branch	Collection Time	Pre-Payment Receipt #	Amount $

Collection Site: _____ **On-site Test performed by Healius / QML Pathology Collector:** ☐ YES ☑ NO

I certify that I witnessed the donor signature and that the specimen identified on this form was provided to me by the donor whose consent and certification appears above, bears the same identification as set forth above, and that the specimen has been collected in accordance with the AS/NZS 4308:2008 Standard.

I hold a certificate in Specimen Collection for Drugs of Abuse. | *Cross out if not applicable* Time

Name of Collector: _____ **Collector's Signature:** _____ **Date:** ____ / ____ / ____

INITIAL TEST RESULTS

SPECIMEN INTEGRITY CHECK *MUST BE COMPLETED*

TEMP (ºC) Read within 4 mins (Circle)	Recollect	33	34	35	36	37	38	Recollect

Visual Inspection of Sample

Colourless ☐ Colour ☐ (Record Colour):

Supervision Level:

Observations/Comments:

Creatinine Dipstick Results (Please circle) | **Batch/Lot** | **Expiry Date**

Normal		Abnormal	
100mg/dL	20mg/dL	10mg/dL	0mg/dL

INSTANT SCREEN

Device Name		Drugs	Neg	Non-Neg	Not Tested	Adulterants	Normal	Abnormal	Not Tested
		MET	☐	☐	☐	OX	☐	☐	☐
Batch/Lot		AMP	☐	☐	☐	pH	☐	☐	☐
		COC	☐	☐	☐	CR	☐	☐	☐
Expiry Date		MOR/OPI	☐	☐	☐	NI	☐	☐	☐
		THC	☐	☐	☐	NPB	☐	☐	☐
Collection Date	Collection Time	BZO	☐	☐	☐	Glut	☐	☐	☐
		SYC/K2	☐	☐	☐	S.G.	☐	☐	☐

BREATH ALCOHOL

Device Name	
Serial Number	
Calibration Date	
Result (g/210L)	__.__ __

☐ Proceed to MS Confirmation (requires additional payment) Security Seal No: _____ ☐ Storage of Non-Negative only

CHAIN-OF-CUSTODY (Laboratory use only) Must be handwritten. Do not use stickers.

Received by: Name (Print)	Received by: Signature	Date	Time	Seal Intact	Labels match	Containers received: Falcon tubes	Containers received: Test cup	Containers received: SST	Laboratory Number
				Yes / No	Yes / No				
				Yes / No	Yes / No				
				Yes / No	Yes / No				

COMMERCIAL REQUEST FORM

Patient Surname: ***Given Name:*** ***Sex:*** ***Date of Birth:***

Address: (State Company Name) ***Tel (Home)*** ***Tel (Mobile)***

BODYCARE WORKPLACE SOLUTIONS	**Dr Code**	**Billing Code**
Requested By: Body Care Workplace Solutions Level 1, 48 Cecil St Southbank VIC 3006 Ph: 03 8637 7170	BBW2M	5300

TEST REQUESTED:	
URINE DRUG SCREEN LAB IMMUNOASSAY	DS4
PROCEED TO MS CONFIRMATION FOR ALL NON-NEGATIVE RESULTS.	
Clinical Notes:	
Name of Collector:	Signature:
Site Location:	Collectors Certificate Number:

Any queries please contact Commercial Services on 07 3121 4945

Drug Information

Full Name: _____

Date of Birth: _____

1. Are you presently taking any over-the-counter medication/drugs? (eg. pain killers, Sudafed or other cold and flu medication, cough mixtures, etc). _____

Specific Brand Name Medication/Drug	Reason for Medication	Dosage/Strength per day	Time & Date of Last Dose	How many days did you use it?

2. Are you taking any prescribed medication or drugs (eg. sedatives, pain killers or other)? _____

_____

Specific Brand Name Medication/Drug	Reason for Medication	Dosage/Strength per day	Time & Date of Last Dose	How many days did you use it?

Physician who prescribed drug(s)? _____

3. Any other medication / drugs not previously mentioned? _____

Comments, explanations? _____

_____

_____

Signature: _____ Date: _____