## **Drug Screen Confirmation Test**

#### PHYSICO GOODNA

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 Pathology**

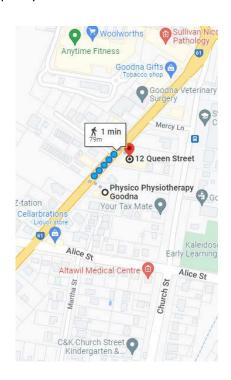
Shop 3, 12 Queen Street, Gladstone QLD 4680



Mon – Fri 07:30 – 11:30, 12:30 – 16:00 Sat 07:00 – 11:00



(07) 3288 5303







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

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

Pathology.

DONOR INFOR	MATIC	N														
Surname:				Giv	<mark>en Nam</mark>	e:				Date of	Birth:	/	/	M	/ <b>F</b> (Ple	ease Circle)
Address: Contact Phone:																
Identity of Dono	or Verif	ied I	<mark>by</mark> : 🗌 Pho	oto ID only	ID Ty	<mark>rpe:</mark>					ID	Numbe	r:			
REQUESTING A	UTHOF	RITY	,													
Company: Boo	dy Car	e W	orkplace \$	Solutions		Compar	ny Coll	lection	Site:			_QML /	Account/Do	octor Cod	e BE	BW2M
Nominated Rep	resenta	ıtive:	:						С	ontact P	hone:					
Reason for testi																
Employment relate	ed Testi	na A	S/N7S 4308	2008	Con	mercial	/ Medic	al Testi	na / Reh	abilitatior	1	Othe	er Testing			
Laboratory Uring										ohol (DSA)			rine Salbutar	nol (SBL)		
☐ Urine Drug Conf								• • •		] + Alcoho			rine Syntheti		ioids (SYC)	)
☐ Laboratory Alco						/ledical U					(/		rine Drug (sp		, ,	•
☐ Instant Urine Dr				h Alcohol (+Ri		Jrine Ethy							erum Carboh			```
DONOR CERTIF			o, 🗀 · Broak	TAIOONOT (*E	-17	-		`	<u>'</u>				oram carbon	yarato Bon	Olone Train	lotottiii (obit)
I certify that the sp with tamper-evider	nt seals i	n my	presence and	I that the info	rmation	orovided (	on this	form and	on the l							
compounds includ						ts to the	request	ting offic	er.				<b>5</b> (		,	
<b>Donor Signat</b>													Date	:/	/	
COLLECTOR CE	ERTIFIC	CATI	ON													
HEALIUS	A = = 1 × 5			nic: BC		Branch	С	ollection	Time	Pre-Payr	nent Re	ceipt#			Amount	
USE ONLY	AFFIX E	BAR	CODE		5300										\$	
<b>Collection Site</b>	:				On-	site Tes	t perf	ormed	by Hea	alius / Q	ML Pa	thology	/ Collector	: 🗆 YE	s 🗹	NO
I certify that I with	nessed t	he do	onor signatur	e and that th												
appears above, be																
I hold a certificate	e in Spec	cime	n Collection f	or Drugs of	Abuse.	C	ross o	ut if not	applicat	ole			Time			
Name of Colle	ector:					C	ollect	tor's <mark>S</mark>	<mark>ignatu</mark>	re:			Date	<b>9:</b>	/	/
INITIAL TEST F	RESULT	ΓS														
SPECIMEN INT	TEGRIT	TY C	HECK *MU	ST BE COI	MPLET	ED*										
TEMP (°C) Read within 4 mins	Recollect	33	34	35 36	37	38	Recollect						ection of Sa	mple		
(Circle)					<u> </u>	•••		C	olourless			(Record C		h/Lot	Evn	iny Doto
Supervision Level:	Observa	ation	s/Comments	•					Creatin	ine Dipst (Please ci		sults	Date	II/LOL	Expi	iry Date
									Normal				Abnormal			
									100mg/c	JL	20m	g/dL	10m	ng/dL	0r	mg/dL
					INST	ANT SC	REEN							BRI	EATH AL	.COHOL
Device Na	me		Drugs	Neg	Non-N	eg Not	Tested	_	terants	Norma	al Ab	normal	Not Tested		Device N	lame
Batab/La	.4		MET						OX						Carial No.	mahan.
Batch/Lo	στ		AMP COC					-	pH CR						Serial Nu	mber
Expiry Da	ate		MOR/OPI					+	NI	$\vdash \vdash$	_			С	alibration	n Date
			THC	П					NPB				П	1		. 5 4 10
Collection Date Coll	lection Tin	ne	BZO						Glut					Res	sult	
			SYC/K2						S.G.					(g/2		
□ Proceed to MS Confirmation (requires additional payment) Security Seal No: □ Storage of Non-Negative only																
CHAIN OF CHE	TORY	Lab		min National Co	a harri											
CHAIN-OF-CUS			oratory use o	miy) Must b	e nandw	ritten. D	o not i	use stic	ters.		0-	otoiners	rossived			
Received by:  Name (Print) Signature		Signature	Date		Time		I Intact	act I I abole match L			tainers received es Test cup SST		Laboratory Number			
IVAIIIC (FIIII	15)		orginature .				Yes	/ No	Yes	/ No	i aiooii ll	1691	oup 001			
							Yes		Yes							
							Yes		Yes							

### **COMMERCIAL REQUEST FORM**



Patient Surname:	Given Name:	Sex:	Date of Birth:
Address: (State Company Name)		Tel (Home)	Tel (Mobile)

Requested By: Body Care Workplace Solutions
Level 1, 48 Cecil St
Southbank VIC 3006
Ph: 03 8637 7170

Dr Code
Billing Code

Billing Code

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:						
ORO LOCATION.							

Any queries please contact Commercial Services on 07 3121 4945

Version Date: August 2016

# **Drug Information**

Full Name:				
Date of Birth:				
Are you presently taking any over medication, cough mixtures, etc)				old and flu
Specific Brand Name Medication/Drug	Reason for Medication	Dosage/Strength per day	Time & Date of Last Dose	How many days did you use it?
Are you taking any prescribed me	edication or drugs (eg. sedat	ives, pain killers or othe	er)?	
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:	Da	ate:		