

# Drug Screen Confirmation Test

## HEALTH FIRST GROUP - MARYBOROUGH

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

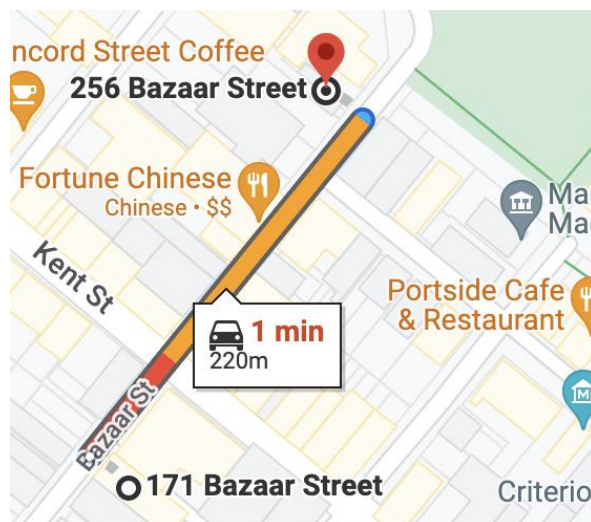
Pathology Room, Maryborough  
Clinic, 256 Bazaar Street,  
Maryborough QLD 4650



Mon, Tues, Thurs & Fri 08:00 – 13:00,  
14:00 – 17:30  
Wed 08:00 – 15:00



07 4121 6856



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

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



## 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
<input checked="" type="checkbox"/> <b>Laboratory Urine Drug Screen (DS4)</b> <input type="checkbox"/> + Alcohol (+ETH)	<input type="checkbox"/> Medical Urine Drug (DS2) <input type="checkbox"/> + Alcohol (DSA)	<input type="checkbox"/> Urine Salbutamol (SBL)
<input type="checkbox"/> Urine Drug Confirmation (Specify Class): _____	<input type="checkbox"/> Urine Drug Screen Rehab (DRP) <input type="checkbox"/> + Alcohol (+ALC)	<input type="checkbox"/> Urine Synthetic Cannabinoids (SYC)
<input type="checkbox"/> Laboratory Alcohol Screen only (DSE)	<input type="checkbox"/> Medical Urine Alcohol only (UAQ)	<input type="checkbox"/> Urine Drug (specify drug): _____ (UDC)
<input type="checkbox"/> Instant Urine Drug Screen (DS8) <input type="checkbox"/> + Breath Alcohol (+BET)	<input type="checkbox"/> Urine Ethyl Glucuronide (ETG)	<input type="checkbox"/> 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 (°C) Read within 4 mins (Circle)	Recollect	33	34	35	36	37	38	Recollect	Visual Inspection of Sample
Supervision Level:	Observations/Comments:								Colourless <input type="checkbox"/> Colour <input type="checkbox"/> (Record Colour):
									Creatinine Dipstick Results (Please circle)
									Batch/Lot
									Expiry Date
									Normal
									Abnormal
									100mg/dL
									20mg/dL
									10mg/dL
									0mg/dL

INSTANT SCREEN									BREATH ALCOHOL	
Device Name	Drugs	Neg	Non-Neg	Not Tested	Adulterants	Normal	Abnormal	Not Tested	Device Name	
Batch/Lot	MET	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	OX	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serial Number	
Expiry Date	AMP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	pH	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Calibration Date	
Collection Date	COC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Result (g/210L)	_____
Collection Time	MOR/OPI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	THC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NPB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	BZO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glut	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	SYC/K2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	S.G.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

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:	Date	Time	Seal Intact	Labels match	Containers received		Laboratory Number
Name (Print)	Signature		Yes / No	Yes / No	Falcon tubes	Test cup	SST
			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
<b>Requested By:</b> 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: \_\_\_\_\_