



Instant Technologies Inc.

Initial Drug Screen Result Form

Specimen ID Number _____

Collection Test Date _____

Company Information: (Information about the company doing the testing)

Company _____
 Address _____ Suite _____
 City _____ State _____ Postal Code _____
 Collector's Name _____ Phone _____
 Specimen Temperature: (90-100 F.) In Range Other _____ Fax _____

Donor Information: (Information about the person being tested)

Donor's Name _____
 ID # or SSN _____
 Identification Type _____ Expiration _____
 Notes _____

Employee ID# or Last Name: _____

Certification Information: (Must be signed by both Donor and Collector)

I hereby certify that the specimen provided is my own and has not been substituted or adulterated. I further agree and grant permission for the testing of my specimen for drug metabolites and/or alcohol.

Donor's Signature _____ Date _____

I hereby certify that I collected the specimen provided by the aforementioned Donor and that it was not substituted or adulterated to the best of my knowledge. The specimen temperature and color were acceptable.

Collector's Signature _____ Date _____

Initial Screen Results: (All "Confirm" or non-negative results must be confirmed using GC/MS)

Drug Name	Device Code	Negative	Confirm	Not Tested	Adulteration Panel Results
Cocaine	COC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Adulteration Panel Results (See color chart and package insert for interpretation)</p> <p><input type="checkbox"/> Oxidant <input type="checkbox"/> In Range Other _____</p> <p><input type="checkbox"/> Specific Gravity <input type="checkbox"/> In Range <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> pH <input type="checkbox"/> In Range <input type="checkbox"/> Other _____</p>
Marijuana	THC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Opiates/Morphine	OPI/MOR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Amphetamines	AMP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methamphetamine	mAMP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Phencyclidine	PCP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Benzodiazepine	BZO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Barbiturates	BAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methadone	MTD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tricyclic Antidepressants	TCA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oxycodone	OXY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Propoxyphene	PPX	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Methylenedioxymethamphetamine	MDMA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ALCOHOL SCREEN	ALC	<input type="checkbox"/>		Level _____	

Last Name

First Name