



PHYSICIAN'S STANDING ORDER FORM (M-36)

By checking the box below, you are requesting that Premier Medical Lab confirm all negative and positive POCT results and run the Premier pain/behavioral/addiction management drug panel (UDA) consisting of the listed drugs/metabolites.

11-nor-delta-9-THC
6-AcetylMorphine
7-Aminoclonazepam
A-Hydroxy-Alprazolam
A-Hydroxy-Midazolam
Alprazolam
Amphetamine
Buprenorphine
BZE/Benzoylcegonine
Carisoprodol
Cocaine
Codeine
Desmethyl-Tramadol
Diazepam
EDDP
Fentanyl
Hydrocodone
Hydromorphone
Hydroxylprazolam
MDMA/Ecstasy
Meprobamate (SOMA)
Meperidine
Methadone
Methamphetamine
Morphine

Norbuprenorphine
Nordiazepam
Norfentanyl
Norhydrocodone
Noroxycodone
Normeperidine
Norpropoxyphene
Nucynta/Tapentadol
Oxazepam
Oxycodone
Oxymorphone
Pentazocine
Propoxyphene
Temazepam
Tramadol
Validity Testing
Ethanol

Please note: PML's testing panels are under continual modification and improvement to meet the challenges and risks associated with the treatment of pain /behavioral/addiction management patients.

Please select the Result Form Format your office prefers by circling your choice below. This will be the standard format transmitted by Premier Medical on all UDA results.

Pain Management **Drug Treatment**
Behavioral Health **Sleep Study**

Please circle the manner in which your office would prefer to receive UDA results from Premier:

WEB BASED

SECURED FAX

PRACTICE INFORMATION

PRACTICE NAME: _____

ADDRESS: _____

PHYSICIAN AUTHORIZATION

I authorize Premier Medical Lab to perform urine drug analysis (UDA) on patients from my practice as indicated on individual laboratory service requisition forms. In addition, I hereby authorize and instruct Premier Medical Lab to run the pain/behavioral/addiction management panel (which may change from time to time) on all samples sent to it by my practice.

This standing order represents my determination that it is both medically necessary and a matter of the prudent practice of medicine to run this panel.

I understand that this standing order will remain in effect until changed by me. I also understand that I may change this order, on a case-by-case basis, by making my testing preferences clear on any laboratory service requisition form.

Physician's Name

Physician's NPI#

Signature

Date

Physician's Name

Physician's NPI#

Signature

Date

Please provide additional physician information on another sheet.