Vermont Department of Health Laboratory - Urine Drug Test Request Form

359 South Park Dr, Colchester, VT 05446 [Mailing: PO Box 1125, Burlington, VT 05402-1125]
1-800-660-9997 (VT only) or 1-802-338-4724; Fax number: (802)338-4706

Specimen Information	For VDH Laboratory Use Only
Date of Collection:_____	Date Received:
Time of Collection:_____	StarLIMS #:

Office Information			Patient Information		
District Office Name:			Patient Last Name	Patient First Name	
Address			Address		
City/Town	State	Zip code	City/Town	State	Zip code
Telephone Number			Patient MRN# or ID#	Specimen ID#	
Cell Phone Number			Date of Birth (MM/DD/YYYY)	Gender ☐ **Male** ☐ **Female**	
Authorization Individual Name (Print)			Supervisor Name (print):		
Authorization Individual Email:			Supervisor Email:		

Urine Drug Screen Analysis Requested:

Please check all requested tests:

- ☐ Cocaine Metabolite (benzoylecgonine)
- ☐ Oxycodone
- ☐ Methamphetamines/MDMA (Ecstasy)
- ☐ Amphetamine
- ☐ Buprenorphine
- ☐ Methadone
- ☐ Opiates
- ☐ Benzodiazepines
- ☐ Cannabinoids (THC)
- ☐ Ethanol Biomarkers (EtG/EtS)*
- ☐ Methylphenidate (Ritalin)
- ☐ Fentanyl
- ☐ Barbiturates
- ☐ Tricyclic Antidepressants
- ☐ Phencyclidine (PCP)
- ☐ Tramadol
- ☐ Zolpidem
- ☐ Propoxyphene
- ☐ Gabapentin
- ☐ Pregabalin

***Quantitative results available upon request.

All samples are analyzed for pH, creatinine, and adulterants.

Reflexive** Confirmation Analysis Requested:

Please check all requested tests:

- ☐ Cocaine Metabolite (benzoylecgonine)
- ☐ Oxycodone
- ☐ Methamphetamines/MDMA (Ecstasy)
- ☐ Amphetamine
- ☐ Buprenorphine
- ☐ Methadone
- ☐ Opiates
- ☐ Benzodiazepines
- ☐ Cannabinoids (THC)
- ☐ Methylphenidate (Ritalin)
- ☐ Fentanyl

**Above reflexive confirmations are performed when screen results are positive. Confirmations will only be performed after in-house screening tests are completed. Additional testing can be requested after report has been received (up to 3 months) with written request from authorizing individual.

Please send written request to
AHS.VDHLabDrugTesting@vermont.gov

FOR DCF CLIENTS PLEASE COMPLETE PAGE 2

A separate form is required for each specimen. All specimens must be labeled with CLIENT NAME and DATE OF BIRTH.

COLLECTION FACILITY USE ONLY		
Specimen Information		
Date of Collection:_____ Time of Collection:_____	Collector's Name: Collector's Initials:	
Observed Collection: □ Yes □ No	Specimen Temperature (°F):	Specimen Volume (mL):
Collector's Comments:		
Collection Facility Information		
Facility Name:		
Address		
City/Town	State	Zip Code
Telephone Number		

CLIENT MUST SIGN BELOW OR SAMPLE WILL NOT BE TESTED

Records Release of Urine drug testing and results

I hereby authorize the release of my urine drug testing and the results of this test to caseworkers and supervisors at the Vermont Department of Children and Families for the purposes of case management. This release expires upon termination of the relationship between DCF and the client.

Client Signature:_____ Date:_____

Guardian Signature (if minor):_____ Date:_____

Client Information		
Last Name	**First Name**	**Date of Birth**

Client Identity Verified by: □ Photo ID □ Client is known to collector/observer/counselor

□ Other form of ID (Please Specify)

VDH Laboratory Use Only

☐ Collection Form Missing ☐ Required Signatures Missing ☐ QNS/Leaked in Transit ☐ Duplicate of # _____

☐ Other:_____