PROVIDER ACKNOWLEDGEMENT FORM

Please indicate panels requested

☐ Comprehensive Panel - Includes the following analytes

Benzodiazepines

- ☐ 7-Aminoclonazepam
- ☐ Alprazolam
- ☐ Clonazepam
- ☐ Diazepam
- ☐ Lorazepam
- ☐ Nordiazepam
- ☐ Oxazepam
- ☐ Temazepam
- ☐ Alpha-Hydroxyalprazolam

Synthetic Opioids

- ☐ EDDP
- ☐ Fentanyl
- ☐ Meperidine
- ☐ Methadone
- ☐ Norfentanyl
- ☐ Normeperidine
- ☐ Norpropoxyphene
- ☐ Propoxyphene
- ☐ Tramadol
- ☐ Tapentadol

Illicit Drugs

- ☐ 6-MAM
- ☐ Benzoylecgonine
- ☐ MDMA
- ☐ PCP
- ☐ THCA
- ☐ JWH-018 N-4-OH pentyl Metabolite
- ☐ JWH-073 N-3-OH butyl Metabolite

Natural and Semi-Synthetic Opioids

- ☐ Buprenorphine
- ☐ Codeine
- ☐ Hydrocodone
- ☐ Hydromorphone
- ☐ Morphine
- ☐ Norbuprenorphine
- ☐ Norhydrocodone
- ☐ Noroxycodone
- ☐ Oxycodone
- ☐ Oxymorphone

Stimulants

- ☐ Amphetamine
- ☐ Methamphetamine

Tricyclic Antidepressants

- ☐ Desipramine
- ☐ Nortriptyline

Other

- ☐ Carisoprodol
- ☐ Ketamine
- ☐ Meprobamate

Specimen Validity

- ☐ Creatinine
- ☐ pH
- ☐ Specific Gravity
- ☐ Oxidants

I understand and hereby acknowledge:

1. I have received and reviewed the complete list of tests offered by Certus Laboratories, LLC and/or its affiliates.
2. I understand that any deviation from the above selected list will be made for each patient via Certus Laboratories, LCC and/or its affiliates requisition forms and will comply with what is medically necessary.
3. I have been informed that in the event medical necessity is requested by patient insurance company, I will provide the necessary documentation; and
4. A Nurse Practitioner (NP, CNP) or Physician Assistant (PA, PA-C) will sent specimens to Certus Laboratories, LLC and/or its affiliates when my practice or facility is billing under his or her NPI number. If my practice or facility does NOT bill under the NP or PA's NPI number for any patient, I understand that the physician must be the one to order the test for that patient.
5. Patients have been informed and consent to the collection and testing of specimen provided and authorize Certus Laboratories, LLC and/or its affiliates to release the result of testing to the ordering facility and/or patient insurance company.

Clinic Name: _____

Provider's Signature: _____ Date: _____

Provider's Name (Please Type or Print): _____ Designation: _____

Once complete, please save the form and email it as an attachment to the below email addresses, or fax the completed and signed form to 228.818.0367.

support@certuslaboratories.net • krivers@certuslaboratories.net • abond@certuslaboratories.net

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