NOVA OCCUPATIONAL HEALTH,INC 8714 SUDLEY ROAD, MANASSAS, VA 20110 PH:703-361-4357 FAX: 703-361-0346

Date:

BLOOD PRESSURE:_____/_____

PULSE:- _____HEIGHT:- _____WT:- _____

SMOKE:- _____ DRINK:- _____LMP:- _____

TD:- _____

ALLERGIES :-_____

Chief Complaint: Suboxone Visit

SOAP:

Medication:-

URINE DRUG TEST: POSITIVE FOR:- NEGATIVE:-

SUBOXONE (buprenorphine and naloxone)THERAPY PROGRESS REPORT (Adapted from Subjective Opiate Withdrawal Scale)

COMPLETED BY PATIENT

Circle the answer that best fits the way you feel now

	Not at all										Extremely
I feel anxious	0	1	2	3	4	5	6	7	8	9	10
I feel like yawning	0	1	2	3	4	5	6	7	8	9	10
I am perspiring	0	1	2	3	4	5	6	7	8	9	10
My nose is running and/or my eyes are watery	0	1	2	3	4	5	6	7	8	9	10
I have goose bumps and/or chills	0	1	2	3	4	5	6	7	8	9	10
I feel nauseated or like I may need to vomit	0	1	2	3	4	5	6	7	8	9	10
I have stomach cramps and/or diarrhea	0	1	2	3	4	5	6	7	8	9	10
My muscles twitch	0	1	2	3	4	5	6	7	8	9	10
I feel dehydrated and/or have not had much appetite	0	1	2	3	4	5	6	7	8	9	10
I am having difficulty sleeping	0	1	2	3	4	5	6	7	8	9	10
I have a headache	0	1	2	3	4	5	6	7	8	9	10
My muscles and bones ache	0	1	2	3	4	5	6	7	8	9	10
I feel like using right now	0	1	2	3	4	5	6	7	8	9	10
I would rate my overall level of withdrawal as	0	1	2	3	4	5	6	7	8	9	10

Do you feel you need a dosage change?	No	Yes	Up	Down
Have you used alcohol or other drugs since your last visit?	No	Yes		
If "yes," please describe what, when, and how much				

COMPLETED BY PHYSICIAN:-

Follow up _____Weeks, Physician Signature:-_____

PINNACLE LABORATORY SERVICES

1410 NE 8th Avenue • Ocala, FL 34470
Phone: 352-236-4782 • Fax: 352-236-4240
Toll Free: 877-736-4347
CLIA ID# 10D2047381

✓ SPECIMEN ID NUMBER 501253

Sample Label 501253
Name
Date of Birth

Practice Name #1067 Aitmed Medical Center
Address 8708 Sudley Rd Manassas, VA 20110
Physician Jerry Lee, MD/Joel Match, MD

1 PATIENT INFORMATION

LAST _____ FIRST _____
DOB ___/___/_____ GENDER ☐ MALE ☐ FEMALE
SOCIAL SECURITY # _____/_____/_____
☐ INSURANCE _____ ☐ SELF-PAY

2 ATTACH A COPY OF PATIENT DEMOGRAPHICS & INSURANCE INFORMATION

3 CUSTOM TEST ORDER (MUST SELECT ONE) AND PRESCRIBED MEDICATIONS (CHECK ALL THAT APPLY)

You must select an option below. If you have not established a custom test, the lab will perform test(s) ordered below.

☐ **Use Custom Test Order**
☐ **Do Not Use Custom Test Order:** Perform test(s) only ordered below.

Amphetamines
- ☐ Amphetamine
- ☐ Methamphetamine
- ☐ Methylphenidate
- ☐ Phentermine

Antipsychotics
- ☐ 7-Hydroxy-Quetiapine
- ☐ 9-Hydroxyresperidone
- ☐ Aripiprazole

Barbiturates
- ☐ Amobarbital/Pentobarbital
- ☐ Butalbital
- ☐ Phenobarbital
- ☐ Secobarbital

Benzodiazepines/Sedatives
- ☐ 7-Aminoclonazepam
- ☐ a-hydroxyalprazolam
- ☐ alprazolam
- ☐ diazepam
- ☐ Lorazepam
- ☐ Nordiazepam
- ☐ Oxazepam
- ☐ Temazepam
- ☐ Zaleplon
- ☐ Zolpidem
- ☐ Zopiclone

Opiates/Opiod Analgesics
- ☐ Buprenorphine
- ☐ Codeine
- ☐ Desmethylitramadol
- ☐ Desmethyltapentadol
- ☐ EDDP
- ☐ Fentanyl
- ☐ Hydocodone
- ☐ Hydromorphone
- ☐ Meperidine
- ☐ Methadone
- ☐ Morphine
- ☐ Naloxone
- ☐ Norbuprenophine
- ☐ Norpropoxyphene
- ☐ Oxycodone
- ☐ Oxymorphone
- ☐ Propoxyphene
- ☐ Tapentadol
- ☐ Tramadol

Antidepressants
- ☐ Amitripyline
- ☐ Citalopram
- ☐ Desipramine
- ☐ Doxepin
- ☐ Duloxetine
- ☐ Imipramine
- ☐ Nortripyline

Ethanol Metabolites
- ☐ Ethyl Glucuronide
- ☐ Ethyl Sulphate

Illicit Drugs
- ☐ 6-monoacetylmorphine
- ☐ Cocaine Metabolite
- ☐ MDA
- ☐ MDEA
- ☐ MDMA
- ☐ Mitragynine
- ☐ Phencyclidine

Muscle Relaxants
- ☐ Carisoprodol
- ☐ Cyclobenzaprine
- ☐ Meprobamate

Cathinones
- ☐ a-PVP
- ☐ MDPV
- ☐ Methylone

Cannabinoids
- ☐ THC-COOH

Synthetic Cannabinoids
- ☐ JWH-018 Metabolite
- ☐ JWH-73-3-OH Metabolite
- ☐ JWH-122 Metabolite
- ☐ UR144/XLR11 Metabolite

Other
- ☐ Cotinine
- ☐ Dextrophan
- ☐ Gabapentin
- ☐ Pregabalin

4 DIAGNOSTIC CODE(S)

_____ _____ _____
_____ _____ _____

5 SPEC. COLLECTION INFO

DATE ___/___/_____ TIME ___:___ AM/PM Collector's Initials _____

6 CONSENT FOR TESTING

I certify that the specimen identified on this form is my own and I have not adulterated it in any way. Patient Initials: _____

I am voluntarily submitting this specimen for analysis by my healthcare provider and/or a third party lab. I authorize the lab to release the results of this test to the ordering healthcare provider. The lab is authorized to bill my insurance provider and to receive payment of benefits for the tests my healthcare provider orders. I further authorize the lab and my healthcare provider to release to my insurance provider any medical information necessary to process this claim. I assign to RAJ Enterprise of Central Florida, LLC d/b/a/ Pinnacle Laboratory Services all rights to collect benefits directly from my insurance company and all rights to proceed against said company in any action, including legal suit, if for any reason said insurance company fails to make payment of benefits due now or in the future.

Please be advised that you have an option of obtaining lab services from another facility and that, upon your request, your physician can provide you with a list of alternative labs facilities.

PATIENT SIGNATURE X _____

7 TEST OPTION

☐ **Oral Fluid Pain Panel**
☐ **Urine Testing**

8 RECORD POINT-OF-CARE TEST (POCT) RESULTS AND MARK WHICH ANALYTES/DRUG CLASSES YOU WANT QUANTITATED

☐ **No POCT Performed. Request lab perform full EIA screen and confirm positives.**

	POS	NEG	Quantative Confirmation		POS	NEG	Quantative Confirmation
BUP	☐	☐	☐	MDMA	☐	☐	☐
mAMP	☐	☐	☐	PCP	☐	☐	☐
MTD	☐	☐	☐	THC	☐	☐	☐
BAR	☐	☐	☐	OXY	☐	☐	☐
BZO	☐	☐	☐	COC	☐	☐	☐
MOP	☐	☐	☐	AMP	☐	☐	☐

Notice to ordering practitioners: Practitioners must order only those tests that are medically necessary for the patient given his or her clinical condition. Practitioners must submit the diagnosis information for all tests ordered and medical necessity should be documented in the patient's medical record subject to sanctions or remedies under civil, criminal, or administrative law. NOTE: Medicare generally does not cover routine screening test.

REFERENCE LAB

All specimens processed by CLIA-licensed facilities

Pinnacle Laboratory Services
1410 NE 8th Avenue
Ocala, FL 34470
CLIA# 10D2047381

Regional General Hospital
125 SW 7th Street
Williston, FL 32696
CLIA# 10D0272938

Putnam County Memorial Hospital
1926 Oak Street
Unionville, MO 63565
CLIA# 26D0441699

9 CLINICIAN SIGNATURE

X _____

Documentation to support medical necessity for all tests ordered should be recorded in the patient's chart. By not signing, Physician signature and test orders are required to be documented in patient's medical chart and available upon request.