COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL
DRUG TESTING FORM

DRUG TESTING INFORMATION			
1. Date of drug test:			2. Time of drug test:
3. Testing method: ☐ Point of Care Testing or ☐ Lab-Based Testing			
4. Type of drug test: Urine ☐ Blood ☐ Saliva ☐ Hair ☐ Sweat ☐ Other ☐			
5. Type of panel (e.g. 5 panel):			
PATIENT INFORMATION			
6. Name (Last, First, and Middle):		7. Date of Birth (MM/DD/YYYY):	8. Medi-Cal or MHLA Number:
9. Address:			
10. Gender:	11. Preferred Language:	12. Race/Ethnicity:	13. Phone Number: Okay to Leave a Message? ☐ Yes ☐ No
PROVIDER AGENCY			
14. Name:	15. Contact Person:	16. Phone Number:	
17. Address:	18. Fax:	19. Email:	

DRUG TEST RESULT		
Substance	**Positive Result**	**Concentration / Level for Lab Test**
Alcohol		
Amphetamines		
THC		
Cocaine		
Opiates		
Phencyclidine (PCP)		
Barbiturates		
3,4-Methylenedioxymethamphetamine (MDMA)		
Benzodiazepines		
Methadone		

Substance	Positive Result	Concentration / Level for Lab Test
Buprenorphine		
Oxycodone, Hydrocodone, Hydromorphone, Oxymorphone		
Meperidine		
Tramadol		
Fentanyl		
Ketamine		
Naloxone		
Nalbuphine		
Butorphanol, Pentazocine		
Propoxyphene		
20. Provider Name:	21. Signature:	22. Date:

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

EXTERNAL SAPC REVIEW *This section will include communication between SAPC and the agency/provider.*

Comments:

Assigned Staff: _____ Reviewed by: _____ Signature: _____ Date: _____

INTERNAL SAPC USE ONLY *This section is reserved for internal SAPC use only.*

Comments:

Assigned Staff: _____ Reviewed by: _____ Signature: _____ Date: _____

DRUG TESTING FORM INSTRUCTIONS

DRUG TESTING INFORMATION

1. Enter the date of the drug test (mm/dd/yyyy)
2. Enter the time of the drug test
3. Enter the testing method i.e. Point of Care Testing (POCT) or Lab Based Testing.
4. Enter the type of drug test
5. Enter the type of drug test panel (for example a 5 panel drug test)

PATIENT INFORMATION

6. Enter the patient name in the order of last name, first name, and middle name.
7. Enter the patient date of birth.
8. Enter the patient Medi-Cal or My Health LA (MHLA) number. If the number is not known, leave the space blank.
9. Enter the patient address.
10. Enter the patient gender
11. Enter the patient preferred language
12. Enter the patient race/ethnicity
13. Enter the patient phone number. Check box to indicate if it is okay to leave a message at this phone number.

PROVIDER AGENCY

14. Enter the agency name
15. Enter the contact person
16. Enter the phone number
17. Enter the address
18. Enter the fax
19. Enter the email

DRUG TEST RESULTS: Please indicate positive or negative drug results. If available, please enter the drug level or concentration.

20. Enter the provider name
21. Enter the provider signature
22. Enter the date

EXTERNAL SAPC REVIEW

This section will include communication between SAPC and the agency/provider

INTERNAL SAPC USE ONLY

This section is reserved for internal SAPC use only.

SUBMIT THE FORM TO:

Fax: (323) 725-2045
Phone: (626) 299-4193

FOR ADDITIONAL SAPC DOCUMENTATION PLEASE SEE
http://publichealth.lacounty.gov/sapc/NetworkProviders/Forms.htm