

Your Laboratory Partner

Requisitions



PAIN MANAGEMENT REQUISITION

Patient (Last, First, MI) _____

Sex _____ Date of Birth (mm/dd/yyyy) _____ Patient Phone # _____

Comments _____ Patient ID # _____

Date of Collection (required) TIME: _____ Site _____ Patient SSN _____

Guarantor (Last, First, MI) _____ Insurance Name _____

Address _____ Insurance Number(s) _____

City _____ State _____ Zip _____ Group Number(s) _____

Subscriber Name _____

State _____ Zip _____ Patient Relationship to Subscriber: Self Spouse Dependent

I have provided my specimen(s) to the collector; that I have not adulterated it in any way and each specimen container used was sealed with a tamper evident seal in my presence.

Your healthcare provider has requested that the tests indicated below be performed on your specimen. PAML will bill your insurance or other coverage when indicated above and will credit your bill for payments made by these providers. However, you are responsible for paying any deductibles, co-pays, or non covered expenses for this testing. For more questions call 800-433-1583 or go online to www.paml.com.

Patient's Signature _____

Tests to be Performed		Patient's Current Medications Date & Time of Last Dose	
<input type="checkbox"/> PMP1 - Amps/COC/THC/Opiates/PCP/Prop/Alcohol	<input type="checkbox"/> Hydrocodone _____	<input type="checkbox"/> Meprobamate _____	
<input type="checkbox"/> PMP2 - Amps/COC/THC/Opiates/PCP/Prop/Alcohol/Barb/Benz/Methadone	<input type="checkbox"/> Hydromorphone _____	<input type="checkbox"/> Fentanyl _____	
<input type="checkbox"/> PMP3 - Amps/COC/THC/Opiates/PCP/Prop/Alcohol/Barb/Benz/Methadone/Meperidine/Tramadol/Acetaminophen	<input type="checkbox"/> Oxycodone _____	<input type="checkbox"/> Methadone _____	
<input type="checkbox"/> PMP4 - Amps/COC/THC/Opiates/PCP/Prop/Alcohol/Barb/Benz/Methadone/Meperidine/Tramadol/Acetaminophen/Fentanyl/Carisoprodol/Meprobamate/Buprenorphine/ETG/ETS	<input type="checkbox"/> Oxymorphone _____	<input type="checkbox"/> Propoxyphene _____	
SINGLE TESTS*	<input type="checkbox"/> Morphine _____	<input type="checkbox"/> Tramadol _____	
<input type="checkbox"/> Acetaminophen (ACETAM)	<input type="checkbox"/> Codeine _____	<input type="checkbox"/> THC/Marinol _____	
<input type="checkbox"/> Alcohol (ALCOH)	<input type="checkbox"/> Buprenorphine _____	<input type="checkbox"/> Amphet/Adderall _____	
<input type="checkbox"/> Amphetamines (AMP)	<input type="checkbox"/> Carisoprodol _____	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Barbiturates (BARB)	<input type="checkbox"/> Cannabinoids (THC) CANN20		
<input type="checkbox"/> Benzodiazepines (BENZ)	<input type="checkbox"/> Carisoprodol/ Meprobamate (MEPCAR)		
<input type="checkbox"/> Buprenorphine (CPBUP)	<input type="checkbox"/> Cocaine (COC)		
	<input type="checkbox"/> Meperidine (MEPU)		
	<input type="checkbox"/> Opiates (CPOP7)		
	<input type="checkbox"/> Phencyclidine (PCP)		
	<input type="checkbox"/> Propoxyphene (PROPOXI)		
	<input type="checkbox"/> Tramadol (TRAMU)		
	<input type="checkbox"/> Methadone (METD)		
*Single Tests can be ordered individually or added to a panel			

Notes to Laboratory _____

Date _____ Donor's Initials _____

(A)

CONSECUTIVE BARCODE
WXXXXXXXXXX

Date _____ Donor's Initials _____

(B)

CONSECUTIVE BARCODE
WXXXXXXXXXX

CONSECUTIVE BARCODE
WXXXXXXXXXX

(A) _____ (B) _____

Tests can be ordered singularly, in panels, or both.

An accurate interpretive report is a critical tool for the clinician treating chronic pain. Our Pain Management requisition makes it easy to provide the pertinent medication information on your patient to assure a complete report.

The clinician can document concerns or add comments that will be reviewed by scientists upon arrival at the laboratory.

Specimen seals are used to assure the patient that proper identification and security measures are met.

For more information, please contact your local marketing representative.

www.paml.com

