

**TEST ORDER INFORMATION**

Client: REQUEST A TEST ORAL FLUID	Donor Name:
ATTN:	Employee ID:
7027 MILL RD., STE 201	Phone #:
BRECKSVILLE, OH 44141	Reason for test:
Account #:	

**SPECIMEN COLLECTION INFORMATION**

Collection Site:	Collector Name:
	Specimen #:
	Collected:
Phone #:	
Site ID:	

**SPECIMEN TEST INFORMATION**

DOT Account: NO	Received:
Employer from CCF: REQUEST A TEST ORAL FLUID	Reported:

Test	Screening Cutoff	Confirm Cutoff	Confirm Unit Quant	Result
<b>Oral Fluids:</b>				
Amphetamines	50	50	ng/mL	Negative
Barbiturates	50	50	ng/mL	Negative
Benzodiazepines	20	20	ng/mL	Negative
Cocaine	20	8	ng/mL	Negative
Marijuana Metab.	4	2	ng/mL	Negative
Methadone	10	25	ng/mL	Negative
Opiates	40	40	ng/mL	Negative
Oxycodone	40	40	ng/mL	Negative
PCP	10	10	ng/mL	Negative
Propoxyphene	40	10	ng/mL	Negative

END OF REPORT