Department of Pathology
Point of Care
Urine Drug Screen Reporting Form

Test Performed by: _____ _____ (Name) (Time)	Date of Service, Ordering Provider Patient Name Attach Patient Demographics Label Patient MRN, DOB (at least 2 patient identifiers) Patient Sex, Age, CSN

Adulterants					
Creatinine (circle one)	**Abnormal**		**Normal**		
(Read at 45 seconds)	Neg	10	20	50	100	200

Specific Gravity (circle one)	**Abnormal**		**Normal**		
(Read at 45 seconds)	1	≥1.030	1.005	1.015	1.025

Oxidant/Bleach (circle one) (Read at 30 seconds)	Positive	Negative

Drug (Read at 5 minutes)	**Result** (POS/NEG)	**Control** (✔)
AMP Amphetamines *Cut-off Level 1000 ng/ml		
BAR Barbiturates *Cut-off Level 300 ng/ml		
BUP Buprenorphine *Cut-off Level 10 ng/ml		
BZO Benzodiazepine *Cut-off Level 300 ng/ml		
COC Cocaine *Cut-off Level 300 ng/ml		
MET Methamphetamine *Cut-off Level 1000 ng/ml		
OPI300 Morphine *Cut-off Level 300 ng/ml		
OXY Oxycodone *Cut-off Level 100 ng/ml		
MTD Methadone *Cut-off Level 300 ng/ml		
THC Marijuana *Cut-off Level 50 ng/ml		

Fentanyl is not detected in this assay.   Time in hours since last dose:_____

Record results in the correct box above.
Positive - enter POS. Result is positive when there is **ONE** line is seen (control line) and no band in
Negative- enter NEG. Result is negative when there are **TWO** lines seen (control and test line).
Control line present, enter ✔ .

If no control line present the test is invalid, enter **INVALID.** Repeat test with new iCup**.**