Phoenix Center
Prevent • Treat • Recover

Drug Testing Referral Form

Client Name: _____ DOB: _____

Referring Agency: _____ Fax: _____

Contact Name: _____ Phone: _____

Reason for Referral: _____

Please check the appropriate boxes for recommended services:

☐ **6-panel Instant Drug Screen** **Fee: $20.00**
(Marijuana, Amphetamine, Opiates, Methamphetamines, Cocaine, Benzodiazepines)

☐ **12-panel Instant Drug Screen** **Fee: $20.00**
(Marijuana, Cocaine, Morphine, Amphetamine, Methamphetamine, Phencyclidine (PCP),Benzodiazepines, Barbiturates, Buprenorphine, Ecstasy, Methadone, Oxycodone)

☐ **8-panel Lab Drug Screen** **Fee: $35.00**
(Alcohol, Amphetamine, Barbiturate, Benzodiazepines, Cocaine, Opiates, Phencyclidine (PCP), Marijuana)

☐ **Other:** _____ **Fee:** _____
(Please refer to list of available tests and pricing)

☐ **OBSERVED SCREEN REQUESTED**

You must appear for your drug test on: _____

Hours: Monday thru Thursday, 8:30AM – 4:30PM; Friday 8:30AM – 1:00PM

Please bring Photo Identification (school ID, driver's license, state ID, photo ID bank card, etc. will be accepted).

Payment is required prior to testing.

I understand that test results will be handled in a confidential manner and results will be forwarded to my referral source. I realize I will be asked to sign a release of information to release my results.

_____ _____
Client Signature Date