COMPASS LABORATORY SERVICES

# TOXICOLOGY COLLECTION PROCEDURES AND FAQS

# COMPASS LABORATORY SERVICES BILLING POLICY

Compass Laboratory Services believes that each patient is unique with individual risk factors including genetic composition, lifestyle, and comorbidities. Through provision of industry leading prescription drug management/compliance and clinical diagnostics, Compass gives providers and patients the information necessary to obtain the most detailed understanding of their risk and best treatment options. Compass also believes that these services must be affordable for patients, their health insurers, and Compass.
As a general rule, three different types of insurers pay for Compass services on behalf of our patients: government programs; in-network commercial insurers; and out-of-network commercial insurers. In addition, our uninsured patients may also pay us directly. It is Compass' policy that all patients are billed in accordance with the guidelines provided.

**GOVERNMENT PROGRAMS (MEDICARE, MANAGED MEDICAID):**
Compass testing is covered by traditional Medicare and other government health insurance programs. Compass does not bill Medicare fee-for-service patients, however, in accordance with governmental policy; governmental plans may require patient payment of co-pays and deductibles which Compass must bill.

**IN-NETWORK COVERAGE (COMMERCIAL INSURANCE):**
Compass works with most major insurers to provide in-network coverage. As a result, Compass is in-network with many of the major insurance carriers. Compass will bill any patient covered by an insurance company with which Compass is an in-network laboratory the patient responsibility as required by his or her individual plan.

**OUT-OF-NETWORK COVERAGE (COMMERCIAL INSURANCE):**
In the event Compass is out-of-network with a patient's commercial health insurer, Compass will bill the insurance company, as well as the patient for any patient responsibility required by his or her individual plan.
In the event that the insurance does not cover the services rendered (denied as non-covered), the patient will be considered self-pay (see uninsured-self-pay).

**UNINSURED-PATIENTS/SELF-PAY:**
A discount may be offered to patients who are uninsured, or their insurance does not cover the services rendered. Compass will bill uninsured/self-pay patients at the price indicated per the Uninsured/Self-Pay Patient Pricing Policy. Discount will be provided to all uninsured or self-pay patients without discrimination.

**PAYMENT PLANS:**
The patient payment plan allows for the balance to be divided into monthly payments. Any missed payment will render the payment plan agreement null, and the patient will be subject to additional collection efforts per Compass's policies.

**PROMPT PAY:**
Compass may offer discounts to patients for payment in full at the time of the request. This discount serves to offset the cost of additional collections efforts and encourages immediate payment for all balances owed to Compass. Discounts will be considered on a case-by-case basis.

**SMALL BALANCE WRITE OFFS:**
Value is set for balances $4.99 or less. Credit and Debit for commercial payors, debit only for governmental plans.

**HARDSHIP DISCOUNTS:**
Compass understands there are times when a patient may fall into a financial burden, such as being furloughed from work, death in the family, etc. This can create unexpected hardship and difficulty to pay. Compass may offer a hardship discount based on individual circumstances. A decision to provide a hardship discount must be approved by the Compass billing team and documented accordingly.

**BILL CYCLE:**
The patient billing cycle includes a consolidated statement for all dates of service with a total of 3 statements sent to a patient for a given date of service approximately 30 days apart. If no payment is made after 30 days of receipt of the third statement for a given date of service, the account is forwarded for additional payment collection efforts by Compass's internal team.

# CONTACT INFORMATION

**Customer Service: (901) 348 – 5774**

**Toll Free: (877) 836 – 1140**

**Fax: (901) 348 – 5738**

**CUSTOMERSERVICE@COMPASSLABSERVICES.COM**

**Hours of Operation: Monday-Friday 8:00 - 5:00 CST**

# COLLECTION INSTRUCTIONS

**What supplies will I need for Urine prescription drug monitoring (PDM)?**

- Requisitions
- Toxicology Kits (sealable specimen cups and a specimen bag for return)
- Materials for return shipping

**What supplies will I need for PDM Oral Fluid?**

- Requisitions
- Oral Fluid Collection Kits (Including 1 Quantisal collection device) supplied by Compass only. Store kits at room temperature.
- Materials for return shipping

**How do I place a reorder?**
Sales representatives will order the initial supply shipment. A reorder form is also included in this binder (last page).
PLEASE SUBMIT ALL ORDERS IN WRITING, VIA FAX, OR EMAIL.

**Where do I submit the reorder form?**
Submit the reorder form to Compass Customer Service at
customerservice@compasslabservices.com
or by phone at 901-348-5774 or fax 901-348-5738.

How long will it take to receive supplies?
Please order supplies 10 days in advance to ensure no disruption in service.

# PDM URINE REQUISITION

The PDM Requisition is a BLUE requisition for your immediate recognition. This requisition is used for typical drug screening/confirmation. If you create a profile, it will be printed directly on the requisition. You will need to check this profile for testing or choose other tests if you do not want to perform your annual profile.

- ***PLEASE DO NOT STAPLE THE REQUISITION OR ANY SUBMITTED PAPERWORK TO ALLOW PROPER DOCUMENT SCANNING.***
- **Every requisition must have two forms of identification**. Forms of identification include legal first AND last name, social security number, and date of birth.
- **Every specimen must have two forms of identification**. The Specimen ID Number serves as 1 identifier. The 2nd identifier may be the patient's date of birth, or legal first AND last names.
- The ordering physician MUST BE PROVIDED and match a physician listed on file for the account.
- Diagnosis codes must be provided. Please provide all appropriate diagnosis codes; these should align with notations in the patient records.
- Mark medications from the list on the requisition. If the drug is not on the list, please provide the medication by writing in the appropriate section on the requisition. Please do not send a medication list.

**What if the requisition is not completed correctly?**

If the requisition is filled out incorrectly, an affidavit will be sent to the clinic for the needed information. *It is important to remember that specimens are held, and reports are not released until corrected information is received. Timeliness is extremely important*.

**Additionally, below are examples of the most common issues:**

- The patient name on the bottle seal does not match the patient name on the requisition.
- The barcode label on the specimen does not match the barcode on the requisition **(Reject)**
- Insurance information is not provided, and the patient is not selected as a self-pay patient
- Correction fluid is used to correct a requisition error. ***DO NOT USE CORRECTION FLUID. In the event of error, please mark through the error with a single line, correct it, and initial and date next to the correction.***
- Mismatched demographic information between the requisition and any provided patient data sheets
- The specimen cup is not labeled or if the patient information on the cup is inconsistent with the requisition **(Reject)**

**In the event a requisition is incomplete, will the specimen still be processed?**

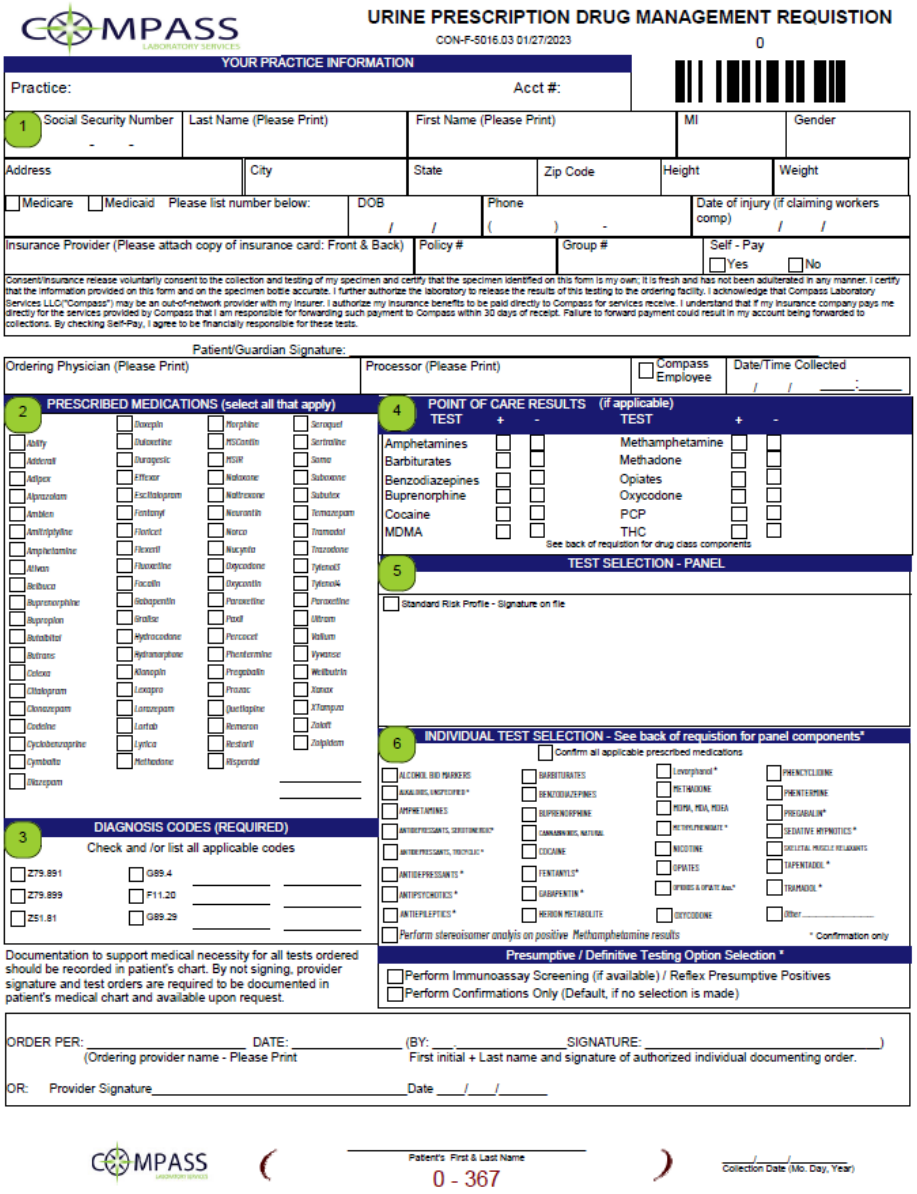
In most instances the specimen will be processed but results held until the information is received. There are, however, some instances which preclude Compass from processing the specimen until the information is completed and returned:

- Account information absent on the requisition
- The requisition is not a Compass Laboratory requisition
- Tests are not clearly marked

**Will a specimen ever be rejected?**

There are some instances where Compass has no alternative but to reject specimens. These reasons include:

- The specimen cup has no unique identifiers.
- Specimen leakage during transit
- Mismatch between requisition and specimen seal.
- Specimen received past stability.



COMPASS LABORATORY SERVICES

**URINE PRESCRIPTION DRUG MANAGEMENT REQUISTION**

CON-F-5016.03 01/27/2023

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**YOUR PRACTICE INFORMATION**

Practice: Acct #:

1 Social Security Number - - | Last Name (Please Print) | First Name (Please Print) | MI | Gender

Address | City | State | Zip Code | Height | Weight

☐ Medicare ☐ Medicaid Please list number below: | DOB / / | Phone ( ) - | Date of injury (if claiming workers comp) / /

Insurance Provider (Please attach copy of insurance card: Front & Back) | Policy # | Group # | Self - Pay ☐ Yes ☐ No

Consent/Insurance release voluntarily consent to the collection and testing of my specimen and certify that the specimen identified on this form is my own; it is fresh and has not been adulterated in any manner. I certify that the information provided on this form and on the specimen bottle accurate. I further authorize the laboratory to release the results of this testing to the ordering facility. I acknowledge that Compass Laboratory Services LLC("Compass") may be an out-of-network provider with my insurer. I authorize my insurance benefits to be paid directly to Compass for services receive. I understand that if my insurance company pays me directly for the services provided by Compass that I am responsible for forwarding such payment to Compass within 30 days of receipt. Failure to forward payment could result in my account being forwarded to collections. By checking Self-Pay, I agree to be financially responsible for these tests.

Patient/Guardian Signature: _____

Ordering Physician (Please Print) | Processor (Please Print) | ☐ Compass Employee | Date/Time Collected / / ____:____

2 **PRESCRIBED MEDICATIONS (select all that apply)**

| | | | |
|---|---|---|---|
| ☐ Abilify | ☐ Doxepin | ☐ Morphine | ☐ Seroquel |
| ☐ Adderall | ☐ Duloxetine | ☐ MSContin | ☐ Sertraline |
| ☐ Ambien | ☐ Duragesic | ☐ MSIR | ☐ Soma |
| ☐ Ativan | ☐ Effexor | ☐ Naloxone | ☐ Suboxone |
| ☐ Buprenorphine | ☐ Escitalopram | ☐ Naltrexone | ☐ Subutex |
| ☐ Bupropion | ☐ Fentanyl | ☐ Neurontin | ☐ Temazepam |
| ☐ Butalbital | ☐ Flexeril | ☐ Norco | ☐ Tramadol |
| ☐ Butrans | ☐ Fluoxetine | ☐ Nucynta | ☐ Trazodone |
| ☐ Celexa | ☐ Focalin | ☐ Oxycodone | ☐ Tylenol3 |
| ☐ Citalopram | ☐ Gabapentin | ☐ Oxycontin | ☐ Tylenol4 |
| ☐ Clonazepam | ☐ Imitrex | ☐ Paroxetine | ☐ Paroxetine |
| ☐ Codeine | ☐ Hydrocodone | ☐ Paxil | ☐ Ultram |
| ☐ Cyclobenzaprine | ☐ Hydromorphone | ☐ Percocet | ☐ Valium |
| ☐ Cymbalta | ☐ Klonopin | ☐ Phentermine | ☐ Vyvanse |
| ☐ Diazepam | ☐ Lexapro | ☐ Progebalin | ☐ Wellbutrin |
| | ☐ Lorazepam | ☐ Prozac | ☐ Xanax |
| | ☐ Lortab | ☐ Quetiapine | ☐ XTampza |
| | ☐ Lyrica | ☐ Remeron | ☐ Zoloft |
| | ☐ Methadone | ☐ Restoril | ☐ Zolpidem |
| | | ☐ Risperdal | |

3 **DIAGNOSIS CODES (REQUIRED)**

Check and /or list all applicable codes

| | | | |
|---|---|---|---|
| ☐ Z79.891 | ☐ G89.4 | | |
| ☐ Z79.899 | ☐ F11.20 | | |
| ☐ Z51.81 | ☐ G89.29 | | |

Documentation to support medical necessity for all tests ordered should be recorded in patient's chart. By not signing, provider signature and test orders are required to be documented in patient's medical chart and available upon request.

4 **POINT OF CARE RESULTS (if applicable)**

| TEST | + | - | TEST | + | - |
|---|---|---|---|---|---|
| Amphetamines | ☐ | ☐ | Methamphetamine | ☐ | ☐ |
| Barbiturates | ☐ | ☐ | Methadone | ☐ | ☐ |
| Benzodiazepines | ☐ | ☐ | Opiates | ☐ | ☐ |
| Buprenorphine | ☐ | ☐ | Oxycodone | ☐ | ☐ |
| Cocaine | ☐ | ☐ | PCP | ☐ | ☐ |
| MDMA | ☐ | ☐ | THC | ☐ | ☐ |

See back of requistion for drug class components

5 **TEST SELECTION - PANEL**

☐ Standard Risk Profile - Signature on file

6 **INDIVIDUAL TEST SELECTION - See back of requistion for panel components***

☐ Confirm all applicable prescribed medications

| | | | |
|---|---|---|---|
| ☐ ALCOHOL BIO MARKERS | ☐ BARBITURATES | ☐ Levorphanol * | ☐ PHENCYCLIDINE |
| ☐ ANALOGS, UNSPECIFIED * | ☐ BENZODIAZEPINES | ☐ METHADONE | ☐ PHENTERMINE |
| ☐ AMPHETAMINES | ☐ BUPRENORPHINE | ☐ MDPM, MDA, MDEA | ☐ PREGABALIN* |
| ☐ ANTIDEPRESSANTS, SEROTONERGIC* | ☐ CANNABINOIDS, NATURAL | ☐ METHYLPHENIDATE * | ☐ SEDATIVE HYPNOTICS * |
| ☐ ANTIDEPRESSANTS, TRICYCLIC * | ☐ COCAINE | ☐ NICOTINE | ☐ SKELETAL MUSCLE RELAXANTS |
| ☐ ANTIDEPRESSANTS * | ☐ FENTANYLS* | ☐ OPIATES | ☐ TAPENTADOL * |
| ☐ ANTIPSYCHOTICS * | ☐ GABAPENTIN * | ☐ OPIOIDS & OPIATE Anal* | ☐ TRAMADOL * |
| ☐ ANTIEPILEPTICS * | ☐ HEROIN METABOLITE | ☐ OXYCODONE | ☐ Other _____ |

☐ Perform stereoisomer analysis on positive Methamphetamine results * Confirmation only

**Presumptive / Definitive Testing Option Selection ***

☐ Perform Immunoassay Screening (if available) / Reflex Presumptive Positives

☐ Perform Confirmations Only (Default, if no selection is made)

ORDER PER: _____ DATE: _____ (BY: _____ SIGNATURE: _____)

(Ordering provider name - Please Print) First initial + Last name and signature of authorized individual documenting order.

OR: Provider Signature_____ Date ___/___/_____

COMPASS ( Patient's First & Last Name ) Collection Date (Mo. Day, Year)

0 - 367

Practice Information: Please contact customer service before making changes to the preprinted practice information section. (901-348-5774)

1. *Patient Demographics/ Insurance*: List patient's **LEGAL First and Last name.** List additional unique identifier (SSN or DOB). **All requisitions must have 2 identifiers, (first and last name) + (SSN or DOB)**. Record ordering physician name, date/time of collection, processor name, insurance/payment information, patient address. Have patient/guardian sign and notate if signature belongs to guardian.
2. *Prescribed Medications*: Select all currently prescribed patient medications. ***DO NOT*** provide a separate medication list. For medications not listed, please write in on the lines provided.
3. *Diagnostic Codes*: Check and/or list patient diagnostic codes in ICD10 format
4. *Point of Care Results*: Document here any positive and negative POC results if desired for your records.
5. *Test Selection Panel*: check to select Standard Risk Profile.
6. Individual Test Selection: Select "Confirm all applicable prescribed medications" to order tests for medications listed in Section 2. Make test selections from the Drug Classes provided. To order an individual drug test that is not listed in Section 6, check "Other" and write on the line provided. Select testing methodology: 1. To perform screening and confirm drug classes with positive screening results, select, "Perform Immunoassay Screening (if available)/Reflex Presumptive Positives OR 2. To perform LC/MS/MS confirmation without initial screening, select, "Perform Confirmations Only."

Provider signature required or authorized individual must document order as indicated.

Write the patient's first and last name on the specimen label (**cup seal label must match the legal first and last name on the requisition)**. Write collection date. Place the cup seal label with the specimen ID centered over the properly sealed cup lid. Ensuring proper seal helps prevent leaks and possible rejection of specimen.

# PDM ORAL FLUID REQUISITION

**When do I use oral fluid collection?**

Oral Fluid collections are to be utilized only if the patient cannot provide a sufficient urine specimen

**What supplies will I need for oral fluid collection?**

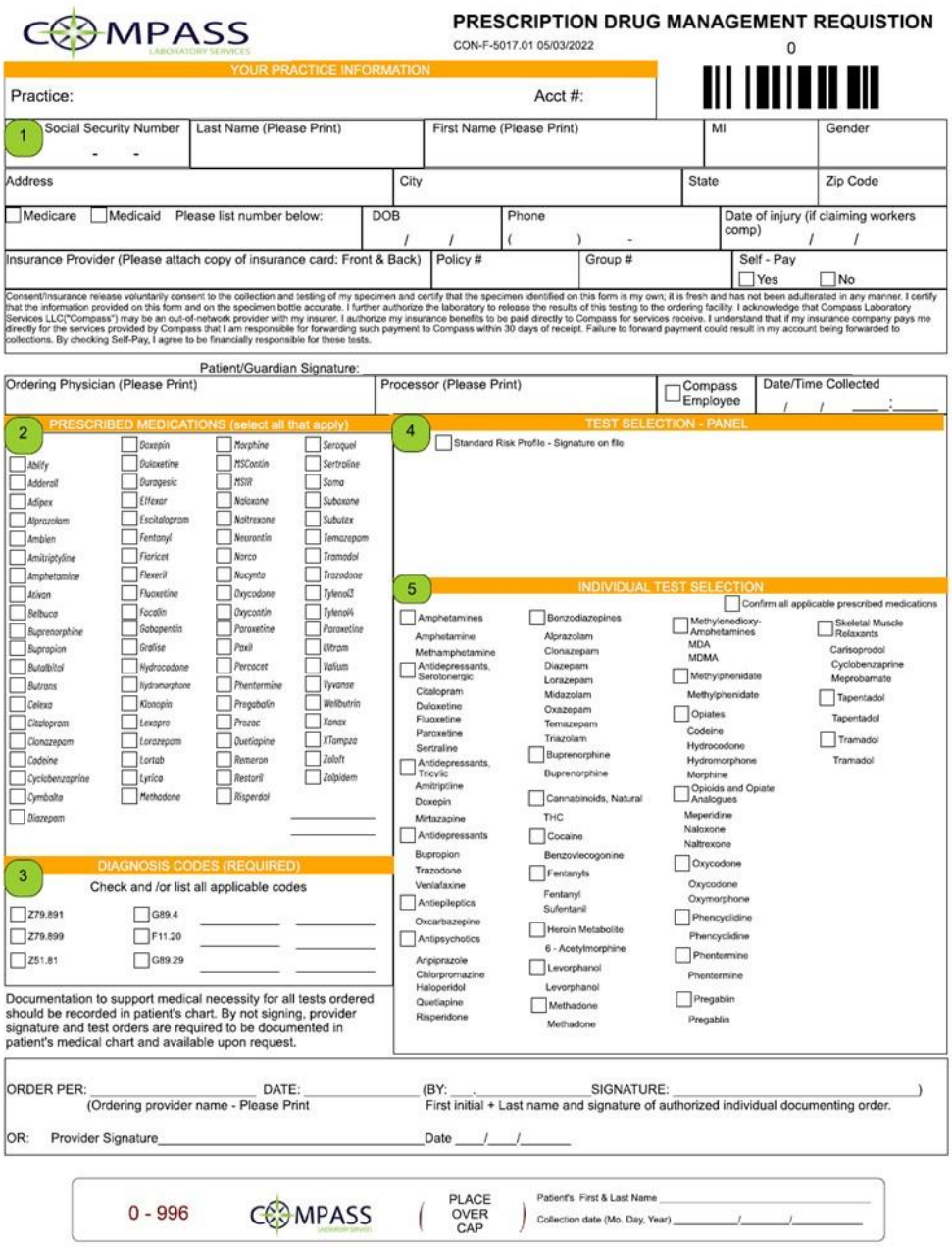
- Requisition - the Oral Fluid Requisition is an ORANGE requisition for your immediate recognition
- ***PLEASE DO NOT STAPLE THE REQUISITION OR ANY SUBMITTED PAPERWORK TO ALLOW PROPER DOCUMENT SCANNING.***
- 1 Quantisal™ collection device provided by Compass
- 1 red top collection tube
- Resealable specimen collection bag

**What steps do I take to collect oral fluid specimens?**

1. Verify donor identity.
2. Check the expiration date on the Quantisal collection device (found on the transport tube with the red cap). DO NOT USE IF EXPIRED. DO NOT COVER EXPIRATION DATE WITH ANY LABEL.
3. Confirm that donor has not consumed food, beverage, chewing tobacco, or sublingual medications for at least 10 minutes prior to specimen collection. If any consumption has occurred, wait an additional 10 minutes before proceeding to the next step.
4. Remove Quantisal collection device from resealable bag. Open at the notch and remove collection device. Do not remove the red top tube at this time.
5. Have patient position collection device under patient's tongue, then mouth should be closed. Patient MUST NOT chew on pad, talk, or remove the collection device until the indicator turns BLUE. Patient should then tilt head down and circulate tongue to help produce saliva. In most cases, the volume adequacy indicator will turn blue within 2 - 5 minutes. If it does not turn blue discard the Quantisal device. Patient should then drink water, wait 10 minutes, and recollect.
6. When the indicator turns BLUE, have the patient hold red top transport tube in an upright position and uncap by pushing up with thumb. DO NOT SPILL OR EMPTY LIQUID FROM THE TUBE.
7. The patient should insert collection device into the uncapped transport tube and replace cap.
8. Snap the cap firmly closed for transport. Ensure the "SNAP" is audible to complete closure. Have patient initial and date barcode sticker at the bottom of the requisition. Place the label on the center of the transport tube as indicated on the label and press down on both sides to secure seal. DO NOT COVER EXPIRATION DATE.
9. Confirm that the requisition is accurate and complete.
10. Fold requisition so that patient information is not visible and place in the back pouch of the resealable bag.
11. Place specimen transport tube in the main compartment of the resealable bag. Seal bag and ship according to proper guidelines as detailed in this document.




**Oral Fluid**



COMPASS LABORATORY SERVICES

**PRESCRIPTION DRUG MANAGEMENT REQUISTION**

CON-F-5017.01 05/03/2022 0

YOUR PRACTICE INFORMATION

Practice: Acct #:

1 Social Security Number - - | Last Name (Please Print) | First Name (Please Print) | MI | Gender

Address | City | State | Zip Code

☐ Medicare ☐ Medicaid Please list number below: | DOB / / | Phone ( ) - | Date of injury (if claiming workers comp) / /

Insurance Provider (Please attach copy of insurance card: Front & Back) | Policy # | Group # | Self - Pay ☐ Yes ☐ No

Consent/Insurance release voluntarily consent to the collection and testing of my specimen and certify that the specimen identified on this form is my own; it is fresh and has not been adulterated in any manner. I certify that the information provided on this form and on the specimen bottle accurate. I further authorize the laboratory to release the results of this testing to the ordering facility. I acknowledge that Compass Laboratory Services LLC("Compass") may be an out-of-network provider with my insurer. I authorize my insurance benefits to be paid directly to Compass for services receive. I understand that if my insurance company pays me directly for the services provided by Compass that I am responsible for forwarding such payment to Compass within 30 days of receipt. Failure to forward payment could result in my account being forwarded to collections. By checking Self-Pay, I agree to be financially responsible for these tests.

Patient/Guardian Signature:

Ordering Physician (Please Print) | Processor (Please Print) | ☐ Compass Employee | Date/Time Collected / / :

2 PRESCRIBED MEDICATIONS (select all that apply)

| | | | |
|---|---|---|---|
| ☐ Abilify | ☐ Doxepin | ☐ Morphine | ☐ Seroquel |
| ☐ Adderall | ☐ Duloxetine | ☐ MSContin | ☐ Sertroline |
| ☐ Adipex | ☐ Duragesic | ☐ MSIR | ☐ Soma |
| ☐ Alprazolam | ☐ Effexor | ☐ Naloxone | ☐ Suboxone |
| ☐ Ambien | ☐ Escitalopram | ☐ Naltrexone | ☐ Subutex |
| ☐ Amitriptyline | ☐ Fentanyl | ☐ Neurontin | ☐ Temazepam |
| ☐ Amphetamine | ☐ Fioricet | ☐ Norco | ☐ Tramadol |
| ☐ Ativan | ☐ Flexeril | ☐ Nucynta | ☐ Trazodone |
| ☐ Belbuca | ☐ Fluoxetine | ☐ Oxycodone | ☐ Tylenol3 |
| ☐ Buprenorphine | ☐ Focalin | ☐ Oxycontin | ☐ Tylenol4 |
| ☐ Bupropion | ☐ Gabapentin | ☐ Paroxetine | ☐ Paroxetine |
| ☐ Butalbital | ☐ Gralise | ☐ Paxil | ☐ Ultram |
| ☐ Butrans | ☐ Hydrocodone | ☐ Percocet | ☐ Valium |
| ☐ Celexa | ☐ Hydromorphone | ☐ Phentermine | ☐ Vyvanse |
| ☐ Citalopram | ☐ Klonopin | ☐ Pregabalin | ☐ Wellbutrin |
| ☐ Clonazepam | ☐ Lexapro | ☐ Prozac | ☐ Xanax |
| ☐ Codeine | ☐ Lorazepam | ☐ Quetiapine | ☐ XTampza |
| ☐ Cyclobenzaprine | ☐ Lortab | ☐ Remeron | ☐ Zoloft |
| ☐ Cymbalta | ☐ Lyrica | ☐ Restoril | ☐ Zolpidem |
| ☐ Diazepam | ☐ Methadone | ☐ Risperdal | |

3 DIAGNOSIS CODES (REQUIRED)

Check and /or list all applicable codes

| | | | |
|---|---|---|---|
| ☐ Z79.891 | ☐ G89.4 | | |
| ☐ Z79.899 | ☐ F11.20 | | |
| ☐ Z51.81 | ☐ G89.29 | | |

Documentation to support medical necessity for all tests ordered should be recorded in patient's chart. By not signing, provider signature and test orders are required to be documented in patient's medical chart and available upon request.

4 TEST SELECTION - PANEL

☐ Standard Risk Profile - Signature on file

5 INDIVIDUAL TEST SELECTION

☐ Confirm all applicable prescribed medications

| | | | |
|---|---|---|---|
| ☐ Amphetamines | ☐ Benzodiazepines | ☐ Methylenedioxy-Amphetamines | ☐ Skeletal Muscle Relaxants |
| Amphetamine | Alprazolam | MDA | Carisoprodol |
| Methamphetamine | Clonazepam | MDMA | Cyclobenzaprine |
| ☐ Antidepressants, Serotonergic | Diazepam | ☐ Methylphenidate | Meprobamate |
| Citalopram | Lorazepam | Methylphenidate | ☐ Tapentadol |
| Duloxetine | Midazolam | ☐ Opiates | Tapentadol |
| Fluoxetine | Oxazepam | Codeine | ☐ Tramadol |
| Paroxetine | Temazepam | Hydrocodone | Tramadol |
| Sertraline | Triazolam | Hydromorphone | |
| ☐ Antidepressants, Tricyclic | ☐ Buprenorphine | Morphine | |
| Amitriptyline | Buprenorphine | ☐ Opioids and Opiate Analogues | |
| Doxepin | ☐ Cannabinoids, Natural | Meperidine | |
| Mirtazapine | THC | Naloxone | |
| ☐ Antidepressants | ☐ Cocaine | Naltrexone | |
| Bupropion | Benzovlecogonine | ☐ Oxycodone | |
| Trazodone | ☐ Fentanyls | Oxycodone | |
| Venlafaxine | Fentanyl | Oxymorphone | |
| ☐ Antiepileptics | Sufentanil | ☐ Phencyclidine | |
| Oxcarbazepine | ☐ Heroin Metabolite | Phencyclidine | |
| ☐ Antipsychotics | 6 - Acetylmorphine | ☐ Phentermine | |
| Aripiprazole | ☐ Levorphanol | Phentermine | |
| Chlorpromazine | Levorphanol | ☐ Pregabalin | |
| Haloperidol | ☐ Methadone | Pregabalin | |
| Quetiapine | Methadone | | |
| Risperidone | | | |

ORDER PER: (Ordering provider name - Please Print) DATE: (BY: First initial + Last name and signature of authorized individual documenting order.) SIGNATURE:

OR: Provider Signature Date ___/___/___

0 - 996 COMPASS ( PLACE OVER CAP ) Patient's First & Last Name Collection date (Mo. Day, Year) ___/___/___

Practice Information: Please contact customer service for assistance with making changes to the preprinted practice information section. (901-348-5774)

1. Patient Demographics/ Insurance: List patient's **LEGAL First and Last name.** List additional unique identifier (SSN or DOB). **All requisitions must have 2 identifiers, (first and last name) + (SSN or DOB)**. Record ordering physician name, date/time of collection, processor name, insurance/payment information, patient address. Have patient/guardian sign their signature, notate if signature belongs to guardian.

2. Prescribed Medications: Check all currently prescribed patient medications. ***DO NOT*** provide a separate medication list. For medications not listed, please use blank lines provided.

*3. Diagnostic Codes*: Check and/or list patient diagnostic codes in ICD10 format

*4. Test Selection Panel*: Select Standard Risk Profile here or use Section 5 to make individual test selections.

5. Individual Test Selection: Select "Confirm All Prescribed Medications," to order tests for medications listed in Section 2. Make test selections from the Drug Classes provided. Please do not cross out individual drugs in a class. To order an individual drug test, write "Add (drug name)," in Section 5 (example: "Add Naloxone").

Specimen Label: Write the patient first and last name on the specimen label (**tube seal label must match the legal first and last name on the requisition)**. Write collection date. Place the transport tube seal label with the specimen ID centered over the transport tube red cap. DO NOT COVER EXPIRATION DATE.

# SPECIMEN PACKAGING AND SHIPPING

**Can I ship urine and oral specimens in the same box or shipping bag?**

Yes! The preferred method is to ship both Urine and Oral in the same shipping box/bag, but ***NOT*** in the same specimen bag. Each specimen requires its own specimen bag.

**How should the specimens look after packaging?**

**URINE** **ORAL**

**Specimen Conditions and Preservation**

Specimens should be packaged and shipped as soon as possible.

Urine specimens should remain at ambient temperature prior to and during transport to the laboratory. If specimens cannot be transported in a timely manner, please contact Customer Services for further instructions.

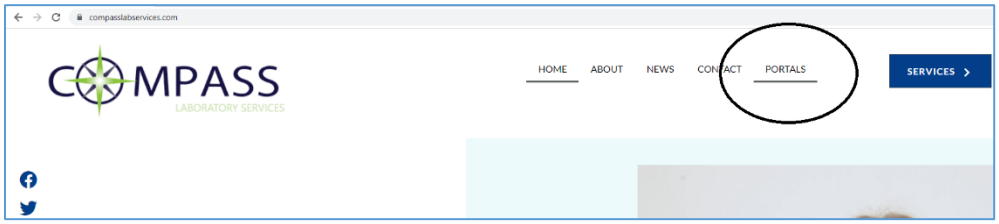
Oral Fluid specimens should be refrigerated until shipment. Oral Fluid specimens are stable for 7 days - please ship as soon as possible. Ship oral fluid specimens at ambient temperature. If oral fluid specimens are received after 7 days from collection, the report will list “Specimen exceeds 7-day stability limit. Discarded.”

**Can I use FedEx or UPS?**

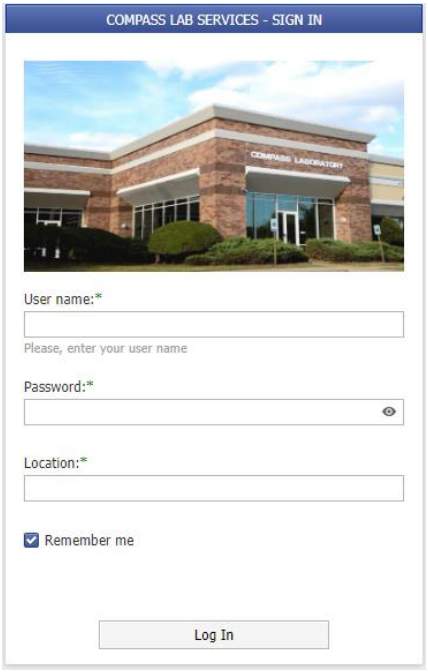
Yes! If using FedEx, place the secure specimens directly in the shipping box. Attach the return shipping label. The return shipping label is located in the bag stating, “Only use these labels when returning PDM (Prescription Drug Management) or Oral Fluid specimens to Compass Laboratory.” If your clinic utilizes UPS for shipping, place the secure specimens in a UPS branded LaboratoryPak and seal the bag. Place the sealed LaboratoryPak in a UPS box. Close and seal the box, and attach the Return Shipping Label stating, “Only use these labels when returning PDM (Prescription Drug Management) or Oral Fluid specimens to Compass Laboratory.”

# WEB PORTAL REPORTING

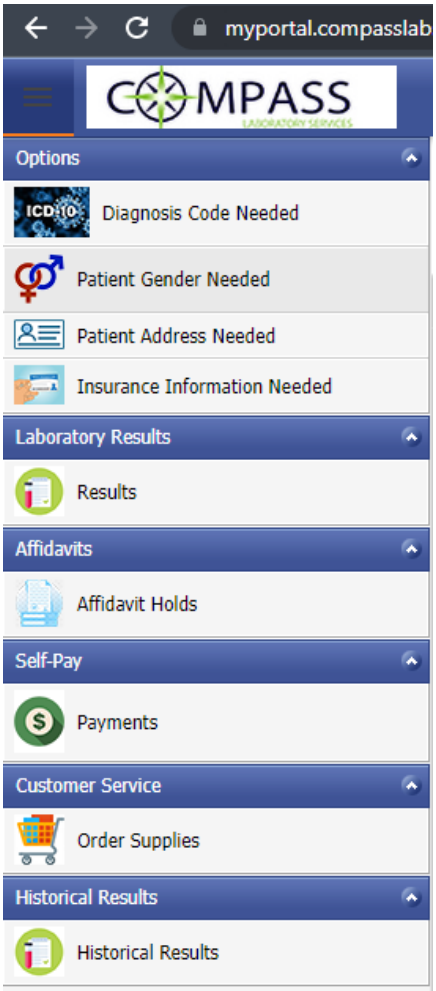
The web portal can be reached from the link at the top right-hand corner of our main site, www.compasslabservices.com.



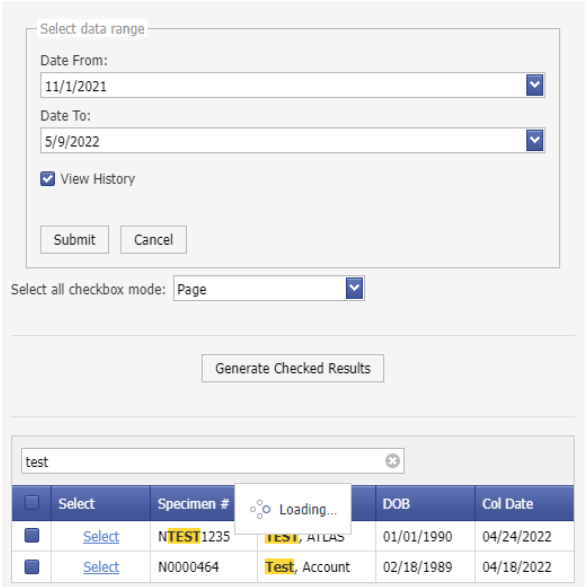

Or enter the following URL:
https://myportal.compasslabservices.com/diagfix/Account/SignIn.aspx




Enter your User name, Password, and Location as provided.
Click Login. Upon login, you will be redirected to the main screen.




On the main screen, make a selection from the navigation toolbar on the left. Click on the Results buttons to view laboratory results. Correct missing information requests in the Options and Affidavits sections. Make payments, or order supplies.




View history for past results, filter by date, or search by names or other criteria.

# PRESCRIPTION DRUG MANAGEMENT SUPPLY ORDER FORM

Clinic Name _____

Shipping Address _____

Requested By _____ Date Ordered _____

| COLLECTION SUPPLIES | Quantity |
|---|---|
| PDM Requisitions (each) | |
| Specimen Cups w/ Bags (each) | |
| Specimen Bags, Non-Biohazard (each) | |
| Small Disposable Gloves (Box of 100)+ | |
| Medium Disposable Gloves (Box of 100)+ | |
| Large Disposable Gloves (Box of 100)+ | |
| Nun Cap Style Specimen Collection Bowl (each) | |

| SHIPPING SUPPLIES | Quantity |
|---|---|
| FedEx Shipping Labels (20 Pack) | |
| UPS Shipping Labels (20 Pack) | |
| Large Shipping Bags (20 Pack) | |
| | |
| | |
| | |
| | |

+Available for Compass Employees Only

**Fax order to 901-348-5738 or email customerservice@compasslabservices.com.**

Supply orders are shipped Ground. Please allow up to 3 business days for receipt.
Please notate this timeline so there is no lapse in your supplies.

LAB USE ONLY

Order Received: _____ Confirmation Number: _____

# ORAL FLUID
# SUPPLY ORDER FORM

Clinic Name _____

Shipping Address _____

Requested By _____ Date Ordered _____

| COLLECTION SUPPLIES | Quantity |
|---|---|
| Oral Fluid Requisitions (each) | |
| Oral Fluid Collection Kits (each) | |
| Specimen Bags, Non-Biohazard (each) | |
| Small Disposable Gloves (Box of 100)+ | |
| Medium Disposable Gloves (Box of 100)+ | |
| Large Disposable Gloves (Box of 100)+ | |

| SHIPPING SUPPLIES | Quantity |
|---|---|
| FedEx Shipping Labels (20 Pack) | |
| UPS Shipping Labels (20 Pack) | |
| Large Shipping Bags (20 Pack) | |
| | |
| | |
| | |

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