URINE DRUG SCREEN
CONFIRMATORY TESTING FORM (2021)

Provincial Clinical Laboratory

Queen Elizabeth Hospital, Charlottetown, PEI
Phone: (902) 894-2300 Fax: (902) 894-2183

Address for Non-PEI Residents Required

Name: _____

Street: Place Label Here

City: _____ Prov./State: _____

Postal Code/Zip: _____

Payment Responsibility ☐ WCB ☐ DVA ☐ DND ☐ RCMP ☐ Self Pay Canadian☐ Self Pay Non-Canadian Provincial Medicare # exp. date:	**DOB: YYYY-MMM-DD**	Sex	Medical Record Number (MRN)

Ordering Physician/NP FIRST & LAST NAME	Location	Copies (Full name required. Fax # required for out of province providers)

All sections below must be completely filled to facilitate the processing of the request.
Please refrain from using other forms or emails to avoid delays in sending the sample to the referral lab.

Specimen Collected	**Form Completed By**	**Relevant History**
Date: YYYY/MMM/DD Time: HH:MM	Name: Date: YYYY/MMM/DD	

Current Medications

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Drugs to be Tested *(For example: Ritalin, Amphetamines etc.)*

1.	3.	5.
2.	4.	6.

Reason for Testing *(All questions must be answered)*

	Yes	**No**
Unexpected urine drug screen result	☐	☐
Did the patient provide a satisfactory explanation for the unexpected result	☐	☐
Will confirmatory testing change patient management	☐	☐

Other Reasons:

For lab use only

Date sample sent to referral lab:	**Date result received:**

Please fill in the form and return it to the lab

Email: *chemistrysendouts@ihis.org*
Fax: 902-894-2183