Color Code - Random Testing Referral Form

Referral Form - Please fax to 256-693-5999 or email to cc@onsitesafetysolutions.com
Questions? Call 256-427-4777

CLIENT INFORMATION

- Full Name: _____
- Date of Birth: _____
- Address: _____
- Phone Number: _____
- Case Number: _____
- Start Date: _____ • End Date: _____

COURT INFORMATION/REFERRING AGENCY

- Court or Referring Agency: _____
- Judge/Contact Name: _____
- Phone Number: _____ • Fax/Email: _____

TESTING OPTIONS

- Urine

☐ 14 Panel Rapid Urine Specimen

☐ Other: _____

All non-negative test will be send to an offsite laboratory for testing.

- Testing Frequency

☐ Weekly ☐ Monthly

☐ Twice a Month ☐ 45 Days Other: _____

Referring Rep Signature: _____ Date: _____

Once the referral form is received, our office will contact the referred client to coordinate scheduling for enrollment or you may send the client to the clinic as a walk-in with the completed form. Office hours are Monday - Friday 7:30 AM - 4:30 PM.