9-panel Drug Test

Patient Information
Name:
Date of Birth:
Gender:
Address:
Contact Number:
Medical History:

Test Details
Test Type:
Date of Test:
Time of Test:
Testing Facility:
Medical professional Conducting Test:

Test Results

Drug Panel	Positive	Negative
Marijuana (THC)		
Cocaine (COC)		
Amphetamines (AMP)		
Methamphetamines (mAMP)		
Opiates (OPI)		
Phencyclidine (PCP)		
Barbiturates (BAR)		
Benzodiazepines (BZO)		
Methadone (MTD)		

Notes

Recommendations

Follow-Up

Medical Professional's Signature: _____

Date: _____