

**Requesting (Medical Clinic or Business):**

Dr. \_\_\_\_\_

**CDL**  
Laboratories5990 Côte-des-neiges, Mtl, (Qc) H3S 1Z5  
Tel: (514) 344-8022 Fax: (514) 344-8024  
E-Mail: [service@cdllabs.com](mailto:service@cdllabs.com)  
Monday to Friday from 8am to 8pm  
Sunday from 10am to 2pm**DRUGS OF ABUSE CHAIN OF CUSTODY FORM**DATE AND TIME OF COLLECTION \_\_\_\_\_ I.D.# \_\_\_\_\_  
(YYYY/MM/DD) (space reserved for CDL)  
LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_  
TELEPHONE \_\_\_\_\_ SEX  M  F DONOR IDENTIFICATION \_\_\_\_\_  
DATE OF BIRTH \_\_\_\_\_  
(YYYY/MM/DD)**Reason for screening**

- 
- PRÉ-EMPLOYMENT
- 
- 
- DURING EMPLOYMENT
- 
- 
- POST ACCIDENT

 OTHER: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_**Tests**

- 
- 7 drugs profile**
- [Cocaine, Opiates, Cannabis, Amphetamines, Phencyclidine, Barbiturates, Benzodiazepine] (DA7B)
- 
- 
- 6 drugs profile (with cannabis)**
- [Cocaine, Opiates, Amphetamines, Phencyclidine, Cannabis, Benzodiazepine] (DA6B50)
- 
- 
- 6 drugs profile (with ethanol)**
- [Cocaine, Opiates, Amphetamines, Phencyclidine, Ethanol, Benzodiazepine] (DA6E)
- 
- 
- 5 drugs profile**
- [Cocaine, Opiates, Cannabis, Amphetamines, Phencyclidine] (DAUB50)
- 
- 
- 4 drugs profile**
- [Amphetamines, Cannabis, Cocaine, Opiates] (DAU450)
- 
- 
- Amphetamines (AMPH)
- 
- Serum Ethanol (SETH)
- 
- 
- Barbiturates (UBAR)
- 
- Methadone (UMDN)
- 
- 
- Benzodiazepine (BENZ)
- 
- Opiates (OPIT)
- 
- 
- Cannabis (CN50)
- 
- Phencyclidine (PCP)
- 
- 
- Cocaine (COKE)
- 
- Propoxyphene (UPXP)
- 
- 
- Ethanol (UETH)
- 
- Other: \_\_\_\_\_

Specify the current drugs that the specimen donor is presently taking or has taken in the last 14 days:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

**TO BE COMPLETED BY DONOR :**

I certify by the present that the urine identified on this form is mine; that it was freshly removed, that it was not falsified and that the identification information furnished on this form as well as on the flask are correct. I consent that this sample should be returned to the laboratory designated by the requesting party, be it CDL Laboratories, to verify and/or identify all falsification and to perform the required tests; In addition, I authorize the disclosure of the results of this test to the person designated by the requesting party.

SIGNATURE OF THE DONOR \_\_\_\_\_

DATE \_\_\_\_\_

**SAMPLE TEMPERATURE:**

Read within 4 minutes

The temperature is between 32.0°C – 38.0°C  
90.0°F – 100.00°F

If not, write : 1. The specimen temperature :

2. Take the body temperature: \_\_\_\_\_ °C

- 
- Yes
- 
- No
- 
- 
- Yes
- 
- No
- 
- 
- Yes
- 
- No
- 
- \_\_\_\_ °C
- 
- \_\_\_\_ °C

Colour \_\_\_\_\_ Clarity \_\_\_\_\_

Quantity Aliquot A : \_\_\_\_\_ (minimum 30mL)

Quantity Aliquot B : \_\_\_\_\_ (minimum 15 mL)

**ATTESTATION OF THE PERSON COLLECTING SAMPLE:**

I certify by the present that the sample identified on this form is the actual one given to me by the donor, that he/she signed the form, and that this sample contains the identification marked above, that it was collected, ticketed and closed hermetically in the presence of the donor. In addition, I certify that the sample was given to me directly by the donor, and it will have been sent to you, duly sealed, to your laboratory by:

Printed name: \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

SAMPLE RETURNED BY	RECEIVED BY Initials/Date/Hour	REASON FOR CHANGE
		Specimen Collection
	CDL Courier	Transport
CDL Courier		Order Entry
		Labelling
		Analysis
		Storage
From storage		Discard

**SPECIMEN VALIDATION (LABORATORY)**Specimen correctly sealed upon reception  Yes  No

Initials/Date : \_\_\_\_\_

Doctors Signature : \_\_\_\_\_