



DONOR INFORMATION REFERRAL FORM

Please Fax this Form and the Donor Consent to:
(519) 657-7413, or complete on-line at www.osad.ca

For assistance please call 1-866-475-6723 Ext.222 or Email: service@osad.ca

ATTENTION: After every two consecutive "Missed Collections", the Contractor must notify the Caseworker/Supervisor for approval to continue testing. Please respond to the OSAD Collector quickly so that collections can resume.

Name of Donor (Please Print): _____

Case File number (To be provided by Caseworker) _____

Address of Collection: _____ PC _____

Donor's Telephone #: (____) _____

Date of Birth: _____ Male Female
Month / Day / Year

Reason for Testing: Random Suspicion Court Order

Other _____

Tests to be performed: Lab. Alcohol Urine Lab. 5-Panel Urine Instant Screen 6-Panel Urine
Breathalyzer Test Lab.10-Panel Urine Instant Screen 10-Panel Urine Lab. Oral Fluid
Instant Screen Oral Fluid **For Paternity (DNA) Analysis please use a Paternity Requisition Order Form**

OSAD recommends Laboratory confirmation for all positive instant drug screens.

Instant Screen Laboratory Confirmation: Yes No

Other Testing _____

HAIR ANALYSIS:

Mother Risk

Drugs: 5-Panel* Cocaine* Marijuana* Opiates* Amphetamine* Methamphetamine*
PCP Nicotine Barbiturates Methadone Benzodiazepines Alcohol – (Separate Collection Required)

Meconium Meconium is ideally collected from the first one or two bowel movements of the neonate during the first 24 hours post-partum. Caseworker must arrange for the hospital to collect the sample. When completed the OSAD Collector will pick-up the sample, complete the forms and ship the sample to Mother Risk.

Time Line: 3 months non-segmented (1X3 cm.) 3 month segmented, (3X1 cm.) 6 month non-segmented, (1X6 cm.)
6 months segmented, (6X1 cm.) 6 months bi-monthly segmented, (3X2 cm.)

Other Segmental Analysis _____

Psychomedics 5-Panel: (COC, THC, OPI, AMP, PCP) 3 months non-segmented 3 month segmented

Frequency of Testing Requested: 1 time only 3 times per week 2 times per week

1 times per week 2 times per month 1 times per month Other: _____

Donor Availability: Anytime Other (Please provide details below)

Authorizing Supervisor _____
Please Print Signature if Required

Caseworker (Please Print): _____

Telephone Number: (____) _____ Ext. _____ Fax: (____) _____

E-mail: _____