BEACON
SPECIMEN COLLECTION SERVICES

NURSE-LED MOBILE SPECIMEN COLLECTION SERVICES

HEALTHCARE PROFESSIONAL REFERRAL FORM

PROFESSIONAL • CONFIDENTIAL • COMPASSIONATE

HP-101

REFERRING PROVIDER INFORMATION

Practice / Organization Name _____

Provider Name _____

Office Contact _____

Phone _____ Fax _____

Email _____

Address _____

City _____ State _____ ZIP _____

PATIENT INFORMATION

Patient Name _____

Date of Birth _____ Phone _____

Email _____

Address _____

City _____ State _____ ZIP _____

PREFERRED CONTACT METHOD: ☐ Phone ☐ Text ☐ Email

REQUESTED SERVICE (Check all that apply)

DRUG & ALCOHOL TESTING

- ☐ DOT Drug Testing
- ☐ Non-DOT Drug Testing
- ☐ Laboratory Urine Drug Testing
- ☐ Instant Urine Drug Screen
- ☐ Hair Follicle Drug Testing
- ☐ Oral Fluid Drug Testing
- ☐ Breath Alcohol Testing

DNA TESTING

- ☐ Legal DNA Testing
- ☐ Peace of Mind DNA Testing
- ☐ Immigration DNA Testing
- ☐ Prenatal DNA Testing
- ☐ Relationship DNA Testing
- ☐ Health & Wellness DNA Testing

ANIMAL DNA TESTING

- ☐ Canine DNA
- ☐ Feline DNA
- ☐ Equine DNA

REASON FOR REFERRAL (Check one)

- ☐ Employment
- ☐ Medical Evaluation
- ☐ Treatment Program
- ☐ Court Requirement
- ☐ Probation Monitoring
- ☐ Attorney Request
- ☐ Personal Testing
- ☐ Family Matter
- ☐ Immigration
- ☐ Other _____

ORDERING INFORMATION

Test Panel / Instructions

_____

_____

Laboratory Preference (if applicable)

_____

Special Collection Instructions

_____

_____

SCHEDULING PREFERENCES

- ☐ Contact Patient Directly
- ☐ Contact Referring Office First

Preferred Appointment Date _____

Preferred Time:

☐ Morning ☐ Afternoon ☐ Flexible

MOBILE COLLECTION LOCATION

- ☐ Patient Home
- ☐ Provider Office
- ☐ Employer Location
- ☐ Beacon Approved Collection Location
- ☐ Other _____

RESULTS DELIVERY

Please send results to:

- ☐ Referring Provider
- ☐ Patient (when authorized)
- ☐ Attorney
- ☐ Employer
- ☐ Other _____

Fax _____

Email _____

Secure Portal _____

ADDITIONAL NOTES

PROVIDER CERTIFICATION

I certify that I am requesting the above specimen collection services for the individual identified on this form and authorize Beacon Specimen Collection Services to contact the patient for scheduling when indicated.

Provider Signature _____

Printed Name _____ **Date** _____

BEACON USE ONLY

Referral Received _____ **Appointment Scheduled** _____ **Collector** _____ **Collection Date** _____

Collection Completed _____ **Laboratory** _____ **Tracking Number** _____ **Case Number** _____

Notes _____

BEACON SPECIMEN COLLECTION SERVICES

7830 Highway 72 West, Suite 100
Madison, AL 35758

256-800-5033 256-800-5045

info@beaconspecimen.com

beaconspecimen.com

Guiding You Toward Answers.