

# BarnesCare BarnesCare | Build A Healthy Business<sup>SM</sup>

5000 MANCHESTER  
ST. LOUIS, MO 63110

## FACSIMILE TRANSMITTAL SHEET

FROM:

Health Information Management

DATE:

TO: City Ferguson

PHONE NUMBER:  
(314)

PHONE NUMBER:  
(314)

FAX NUMBER:  
(314)

FAX NUMBER:  
(314)

RE:

NUMBER OF PAGES INCLUDING COVER SHEET

- URGENT
- FOR REVIEW
- PLEASE COMMENT
- PLEASE REPLY
- PLEASE RECYCLE

TO

---



---



---



---

**Confidential Notice:** The document accompanying this fax transmission may contain confidential information belonging to the sender which is the legally privileged. The information is intended **ONLY** for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or the taking of action in reliance on or regarding the contents of this faxed information is strictly prohibited. If you have received this fax in error, please immediately notify us by telephone or arrange for the return of the original document to us.

12-Aug-2014

Clinical Reference Laboratory

12:37

BJC CORP HEALTH SVCS

NAME: WILSON, DARREN

SAMPLE ID:

DOB: N/S

COLLECTED: 08/09/14

SSN/ID:

RECEIVED: 08/12/14

GENDER: N/S

REPORTED: 08/12/14

SLIP ID:

FAX: (314)

PH: (314)

REF ID: N/S

COLL. SITE ID:

REFERENCE 1: NONDOT DEFAULT

REFERENCE 2:

SITE ADDR: GUARDIAN MEDICAL LOGIST

SITE BRANCH: GUARDIAN MOBL UNIT

N/S, N/S N/S

SITE PHONE: (314)

SITE FAX: (866)

REASON FOR TESTING: POST ACCIDENT

SAMPLE TYPE: URN DRUG SCREEN (5 PANEL)

## URINALYSIS

## RESULT / STATUS

## CUTOFF/EXPECTED VALUES

URINALYSIS	RESULT / STATUS	CUTOFF/EXPECTED VALUES
URN CREATININE	331.2 HIGH	20.0-300.0 mg%

## INITIAL TEST

## RESULT / STATUS

## CUTOFF/EXPECTED VALUES

INITIAL TEST	RESULT / STATUS	CUTOFF/EXPECTED VALUES
COCAINE METABOLITES	..... NEGATIVE	300 ng/mL
AMPHETAMINES (CLASS)	..... NEGATIVE	1000 ng/mL
MARIJUANA METABOLITE	..... NEGATIVE	50 ng/mL
OPIATES	..... NEGATIVE	2000 ng/mL
PHENCYCLIDINE	..... NEGATIVE	25 ng/mL

LAB DIRECTOR:

PHD, DABFT

REPORT CERTIFIED BY

Page 1

Copyright 2014 Clinical Reference Laboratory. All Rights Reserved.  
8433 Quivira Road, Lenexa, Kansas 66215.

FCB: CLS.BJC.CMGT.DEFNON

( end of report )

(The instructions for completing this form are on the back of Copy 3)

**STEP 1. TO BE COMPLETED BY ALCOHOL TECHNICIAN**

Name: Robert Wilson  
 (Print) (First, M.I., Last)

Employee ID No. \_\_\_\_\_

Address: CITY OF Ferguson  
110 Church St  
Ferguson MO 63134

Work Phone Number \_\_\_\_\_

Reason for Test:  Return  Reasonable Susp  Post-Accident  Return to Duty  Follow-up  Pre-employment

RBT IUM 016731  
 DATE 08-09-14  
 TEST NO. 0166  
 IDN  
 6578  
 AS IUM 043910  
 SCREENING  
 C-210L TIME  
 000 AUTO 15:56

**STEP 2. TO BE COMPLETED BY EMPLOYEE**

I hereby declare that I am about to submit to alcohol testing and that the identifying information provided on the form is true and correct.

Date: 8/21/14  
 Date Month Day Year

**STEP 3. TO BE COMPLETED BY ALCOHOL TECHNICIAN**

If the technician conducting the screening test is not the same technician who will be conducting the confirmation test, each technician must complete their own form. I certify that I have conducted alcohol testing on the above-named individual and that I am qualified to operate the testing device(s) identified, and the results are as recorded.

TECHNICIAN:  BRT DEVICE:  SALIVA  BREATH\* 15-Minute Wait:  Yes  No

SCREENING TEST: (For BREATH DEVICE\* write in the space below only if the testing device is not designed to print.)

Testing Device Name	Device Serial # OR Lot # & Exp Date	Activation Time	Reading Time	Result

CONFIRMATION TEST: Result **MUST** be affixed to each copy of this form or printed directly onto the form.

REMARKS: \_\_\_\_\_

Company Name: CHRISTIAN MEDICAL

Company Street Address: ST. LOUIS, MO (314)

Personnel Technician's Name (First, M.I., Last): \_\_\_\_\_ Company City, State, Zip Phone Number \_\_\_\_\_

Signature of Alcohol Technician: \_\_\_\_\_ Date Month Day Year 8/21/14

**STEP 4. TO BE COMPLETED BY EMPLOYEE IF TEST RESULT IS 0.02 OR HIGHER**

I hereby declare that I have submitted to the alcohol test, the results of which are accurately recorded on this form. I understand that I must not drive, perform safety-sensitive duties, or operate heavy equipment if the results are 0.02 or greater.

Signature of Employee: \_\_\_\_\_ Date Month Day Year \_\_\_\_\_