



CLINICAL REFERENCE LABORATORY
 8433 QUIVIRA • LENEXA, KANSAS 66215

BJC CORP HEALTH SVCS



ECIMEN ID NO.

STEP 1: COMPLETED BY COLLECTOR OR EMPLOYER REPRESENTATIVE

A. Employer Name, Address, I.D. No. **ACCT: BJC, CMGT, REF1**
STIX #
City of Ferguson - PD
110 Church St
Ferguson MO 63135

B. MRO Name, Address, Phone and Fax No.

C. Donor I.D. No. _____ Donor Name (F, M, L) *DARRAN WILSON*

D. Reason for Test: Pre-employment Random Return to Duty Follow-up Reasonable Suspicion/Cause Post Accident Other (specify) _____

E. Drug Tests to be Performed: () P700 (O&DSE) P705 (SDSP) () P708 (B-DSE)
 () P710 (10DSE) () P711 (9DSE)

F. Collection Site Name and Address: **GDM, MOBL**
 Name: *GDMMOBL/GUARDIAN MEDICAL HEALTHCARE* Collector Phone No. _____ PH: _____
 Address: _____ Collector Fax No. _____ FX: _____
 City, St, Zip: _____

STEP 2: COMPLETED BY COLLECTOR

Read specimen temperature within 4 minutes. Is temperature between 90° and 100° F? Yes No, enter remark _____

Specimen Collection (CHECK ALL THAT APPLY)
 Urine Split Saliva Observed (Enter Remark)
 Urine Single Blood

REMARKS: _____

STEP 3: Collector affixes container seal(s) to container(s). Collector dates seal(s). Donor initials seal(s). Donor completes STEP 4

STEP 4: COMPLETED BY DONOR

I consent to have my specimen collected by the named collector, analyzed, including drug analysis, by Clinical Reference Laboratory, Inc., its employees, agents, and/or representatives ("CRL"); and the results of that analysis made available to the above named Company/Employer and/or their designee. I certify that I provided my specimen to the collector; that I have not adulterated it in any manner; that each specimen container used was sealed with a tamper-evident seal in my presence; and that the information provided on this form and on the label affixed to each specimen container is correct.

Date of Collection *8/9/20/14*
 Mo. Day Year
 Date of Birth _____
 Mo. Day Year
 Daytime Phone No. _____
 Evening Phone No. _____
 Signature of Donor *DWR*
 SPECIMEN ID NO. _____

STEP 5: CHAIN OF CUSTODY - INITIATED BY COLLECTOR AND COMPLETED BY LABORATORY

I certify that the specimen given to me by the donor identified in the certification section in step 4 of this form was collected, labeled, sealed and released to the Delivery Service noted.

Time and Date of Collection *4:05 AM* AM PM
8/9/20/14
 Mo. Day Year
 (PRINT) Collector's Name (First, MI, Last) _____
 SPECIMEN CONTAINER(S) RELEASED TO:
 Fed Ex UPS Courier Other _____

RECEIVED AT LAB
 Primary Specimen Container Seal Intact
 Yes No, enter remarks below
 SPECIMEN CONTAINER(S) RELEASED TO:
 Signature of Accessioner _____
 (PRINT) Accessioner's Name (First, MI, Last) _____
1/20
 Mo. Day Year

STEP 6: COMPLETED BY MEDICAL REVIEW OFFICER - PRIMARY SPECIMEN

My determination/verification is:
 Negative Positive Test Cancelled Refusal To Test because:
 Dilute Adulterated Substituted

REMARKS: _____

Signature of Medical Review Officer _____ (PRINT) Medical Review Officer's Name (First, MI, Last) _____
 Date (Mo./Day/Yr) *1/20*

STEP 7: COMPLETED BY MEDICAL REVIEW OFFICER - SPLIT SPECIMEN

My determination/verification for the split specimen (if tested) is:
 RECONFIRMED FAILED TO RECONFIRM - REASON _____

Signature of Medical Review Officer _____ (PRINT) Medical Review Officer's Name (First, MI, Last) _____
 Date (Mo./Day/Yr) *1/20*

PRESS HARD - YOU ARE MAKING MULTIPLE COPIES

ALCOHOL TESTING FORM

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

STEP 1: TO BE COMPLETED BY ALCOHOL TECHNICIAN

A: Employee Name Darren Wilson
 (Print) (First, M.I., Last)

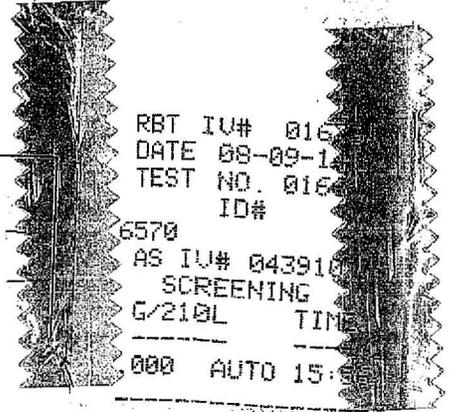
B: SSN or Employee ID No. _____

C: Employer Name CITY OF Ferguson
 Street _____
 City, ST ZIP 110 Church st
Ferguson MO 63135

DER Name and Telephone No. _____
 DER Name _____ DER Phone Number _____

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

Affix or Print Screening Results Here
Affix with Tamper Evident Tape



STEP 2: TO BE COMPLETED BY EMPLOYEE

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

Signature of Employee _____ Date 8/9/14
 Date Month Day Year

Affix or Print Confirmation Results Here
Affix with Tamper Evident Tape

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 that the results are as recorded.

TECHNICIAN: BAT STT 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.)

Test#	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: _____

Affix or Print Additional Results Here
Affix with Tamper Evident Tape

GUARDIAN MEDICAL

Alcohol Technician's Company _____ Company Street Address
ST. LOUIS, MO 63146

(PRINT) Alcohol Technician's Name (First, M.I., Last) _____ Company City, State, Zip _____ Phone Number _____

Signature of Alcohol Technician _____ Date 8/9/14
 Date Month Day Year

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

I certify 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 because the results are 0.02 or greater.

Signature of Employee _____ Date _____
 Date Month Day Year

NORTHWEST HEALTHCARE a part of Christian Hospital

1225 Graham Road
Florissant, MO 63031

Patient: WILSON, DARREN

Sex/Age: M 28y

Address:

Date/Time: 08/09/2014 15:35

R_x Naprosyn 500mg; Twenty (20); Take one by mouth twice daily as needed for pain, with food

; Collaborating physician: _____, MD

NO REF

Signature

Substitution Permitted

Dispense As Written

Signed by:

Collaborating Physician:

DEA Number:

NPI Number:

THIS IS YOUR PRESCRIPTION.

DO NOT LOSE IT.

Take it to a pharmacy as soon as possible so that you may begin taking your medicine.

EMERGENCY CARE DEPARTMENT



Patient: WILSON, DARREN D
 MR#:
 Acct #:
 DOB:

Northwest Healthcare a part of Christian Hospital
 1225 Graham Road
 Florissant, MO 63031

General Emergency Department Discharge Instructions

The exam and treatment you received in the Emergency Department were for an urgent problem and are not intended as complete care. It is important that you follow up with a doctor, nurse practitioner, or physician's assistant for ongoing care. If your symptoms become worse or you do not improve as expected and you are unable to reach your usual health care provider, you should return to the Emergency Department. We are available 24 hours a day.

You were treated in the Emergency Department by:

What to do:

§ Follow the instructions on the additional sheets you were given:

- Please call as soon as possible to make an appointment for follow-up care:

Discharge from ED: The patient is discharged to home . Patient's condition is satisfactory . Discharge occurred after medical screening and evaluation. . The patient is to follow-up with Contact your supervisor at work on the next business day for information on where to get further treatment of your medical problem. If your supevisor has not been contacted by 11AM, have him/her call BJC Occupational Medicine at _____ in the next 1-2 day(s) as needed . Purpose of referral: for re-evaluation and further treatment

- Take this sheet with you when you go to your follow-up visit.
- If you have any problem arranging the follow-up visit, contact the Emergency Department immediately.
- Take all medications as directed.

Your diagnosis is
 Contusion of mandibular joint area (ED)
 Assault by other bodily force (ED)

Diagnosis Instructions: Facial Contusion

Facial Contusion

You have been diagnosed with a facial contusion.

Patient: WILSON, DARREN D

MR#:

Acct #:

DOB:

Contusion is the medical term for a bruise. A facial contusion can be caused by a fall or by being struck in the face.

The skin, muscles and other soft tissues of the face may become swollen and painful. You may have other injuries, like cuts or scrapes. The bones under your face might be bruised.

The doctor does not believe you have injured essential organs, like your eyes, brain or spine.

Apply ice to the face to help with pain and swelling. Place some ice cubes in a re-sealable plastic bag (like Ziploc). Add some water. Seal the bag. Put a thin washcloth between the bag and the skin. Apply the ice bag for at least 20 minutes. Do this at least 4 times per day. It's okay to apply ice longer or more often. NEVER APPLY ICE DIRECTLY TO THE SKIN. Always keep a washcloth between the ice pack and your body. Swelling may increase overnight when your head is down and gravity causes fluids to pool in your face. This should improve within a few hours after you are awake with your head up. Try sleeping with extra pillows to keep your head high.

Use Acetaminophen (Tylenol) or Ibuprofen (Advil or Motrin) to decrease pain and inflammation. The physician will decide if you need a prescription medication.

If your nose bleeds, pinch it closed for 15 minutes. If that does not stop the bleeding, then return here or to the closest Emergency Department.

If you have a cut that requires stitches, then you will receive additional wound care instructions.

One concern after a facial injury is the possibility of other injuries to the head or neck. The doctor has determined that you do not have any other serious injuries and that it is safe for you to go home. If you develop symptoms of a head or neck injury, return immediately to the nearest Emergency Department.

YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS:

- Your headaches are severe or become worse.
- You vomit repeatedly.
- You are lethargic or difficult to awaken or you feel confused or seem intoxicated (drunk).
- You have trouble with coordination or balance, feel dizzy, pass out, or have difficulty speaking or slurred speech.
- Your vision changes or your pupils are unequal in size.

Patient: WILSON, DARREN D

MR#:

Acct #:

DOB:

Medication Reconciliation:

THIS IS A LIST OF THE MEDICATIONS THAT YOU WERE ON:

- Patient not currently taking any medications.

THESE ARE THE MEDICATIONS YOU WERE GIVEN IN THE EMERGENCY ROOM:

- NAPROSYN ORAL 500mgs PO

THESE ARE THE PRESCRIPTIONS THAT YOU WERE GIVEN TODAY:

- New: Naprosyn 500mg; Twenty (20); Take one by mouth twice daily as needed for pain, with food
- New: ; Collaborating physician:

*** If side effects develop, such as a rash, difficulty breathing; or a severe upset stomach, stop the medication and call your doctor or the Emergency Department.*

I, WILSON, DARREN D, understand the instructions and will arrange for follow-up care.

<PTSig>

Patient Signature

<RepSig>

Representative Signature

<StaffSig>

Staff Signature

Patient: WILSON, DARREN D

MR#:

Acct #:

DOB:

<Attach:Nutritional Screening>