



New Direction Testing, LLC

Professional Drug & Alcohol Testing

OUT OF TOWN REFERRAL FORM

Name: _____ Date: _____
(first) (middle) (last)

DOB: _____ Gender: _____ Case #: _____

Begin Date: _____ End Date: _____

PRELIMINARY BREATH TESTS

Daily PBT: Daily am 2x daily am & pm

Random PBT - am: 1x/month 2x/month 4x/month 8x/month

URINE ANALYSIS - AM ONLY, UNLESS APPROVED BY THE COURT

Full Urine Screen Benchmark - Date: _____

Frequency : 1x/month 2x/month 4x/month 8x/months

Referring Agency: _____

Contact Name : _____ Phone: _____

Email: _____ Fax: _____

Send Results Via: Email Fax USPS

Signature: _____

Testing Hours: 5:30 - 9:00 am | 6:00 - 9:00 pm (7 days/week)
Random codes are posted each day at 9:00 PM for the following day.