

Alcohol & Other Drugs Pre-Test Information

(Please Print)

Surname:

Given Name:

Male: Female: Date of Birth:...../...../.....

Company/Organisation:

1. Have you taken, used or consumed anything in the last 14 days that you consider may affect the result of this alcohol and drug test? e.g. prescribed/over the counter medication, pain relief.

Yes: No:

2. If yes, do you wish to disclose what you have taken, used or consumed?
(This information is optional and confidential)

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.....
.....

Date and time of last use:

Donor Signature: Date:

Office use only:

Ref:/.....

Identity of donor verified by:

Photo ID: Other: ID Type: ID Number:

Temp:..... Creatinine:..... Drugs: (please circle) N U)