Printed Employee Name: _____ License #: _____ Location: _____

NexScreen™ Cup Urine Drug Screen Quality Control Test

Test Cup Lot Number:	Test Cup Expiration Date:

I have read the **NexScreen Cup Urine Drug Screen** policy and procedure before taking this exam as indicated by my initials here: _____. Perform both Positive and Negative Quality Controls.

POSITIVE QUALITY CONTROL TEST

POSITIVE Control Lot #: _____ POSITIVE Control Exp Date: _____

Drug (Analyte)	MET	PCP	COC	MD MA	OPI	OXY	AMP	MTD	BZO	BAR	TCA	BUP	THC
Control Line	P A	P A	P A	P A	P A	P A	P A	P A	P A	P A	P A	P A	P A
Test Line	P A	P A	P A	P A	P A	P A	P A	P A	P A	P A	P A	P A	P A
Positive Control Results	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV

NEGATIVE QUALITY CONTROL TEST

NEGATIVE Control Lot #: _____ NEGATIVE Control Exp Date: _____

Drug (Analyte)	MET	PCP	COC	MD MA	OPI	OXY	AMP	MTD	BZO	BAR	TCA	BUP	THC
Control Line	P A	P A	P A	P A	P A	P A	P A	P A	P A	P A	P A	P A	P A
Test Line	P A	P A	P A	P A	P A	P A	P A	P A	P A	P A	P A	P A	P A
Negative Control Results	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV	POS NEG INV

I Performed This Test	**I Observed This Test Being Performed**
Signature: **Date:**	**Printed Name:** **Date:**

Score: PASSED _____ FAILED _____

Upon Completion: FAX COPY (415.206.3451) to Point of Care Testing Services or send copy to 2M14. Unit Manager is encouraged to retain a copy in employee or unit file.