



**BIOPHARMA INSTITUTE**  
 AbuseCheck™ Hair Alcohol & Drug Abuse Testing  
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 Phone: (201) 800-4430 | (888) 4-BIO-LRN  
[www.BioPharmaInstitute.com](http://www.BioPharmaInstitute.com) | [www.AbuseCheck.com](http://www.AbuseCheck.com)

V8 (06/09/11)

Barcode & Specimen ID (LAB ONLY)

Medicals Reference:

**Chain of Custody Form: To be Completed by Collector**

Requesting Organization:	Collection Site:
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**Hair Test (Circle ONE): FAEE HAT - EtG HAT - 5-Panel Drug - 9-Panel Drug**

Type of sample	Reason for Testing / Remarks
<b>ONE TYPE ONLY</b>	
<input type="checkbox"/> Head hair	Has donor history of excessive alcohol consumption? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Body hair	Abstinent since? _____
Type of Body Hair:	Other: _____

**Type of identification**

<input type="checkbox"/> Photo	<input type="checkbox"/> Letter from Solicitor or Social Worker
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**Collection details**

Signature of collector:	(PRINT) Collector's name:	Time of collection:	Date of collection:
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**Donor details (PLEASE PRINT)**

Surname: \_\_\_\_\_

First name: \_\_\_\_\_

Ethnicity: \_\_\_\_\_  Female:  Male:

I confirm that I have provided the hair sample to the specimen collector. I have observed the specimen being placed and sealed in the appropriate sample collection kit. I confirm that the information on this form and the specimen collection labels are correct. I hereby give consent for the samples to be sent to the laboratory for testing for evidence of alcohol use. Furthermore, I understand that the results will be communicated confidentially to the instructing solicitor or a designated representative.

Signature of donor:	Date of birth:	Contact number:
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**Additional comment (please tick and provide additional details if required)**

Are you taking any prescribed or non-prescribed medicine? If YES please list:  
 No  Yes \_\_\_\_\_

Have you experienced recent drastic weight loss?  
 No  Yes **Amount lost and when:** \_\_\_\_\_

Have you had extensive hair bleaching in the last 3 months?  
 No  Yes **Approx. Weight of Donor:** \_\_\_\_\_

Do you have hair extensions? If YES what length of real hair is available at the root end (before the extensions begin)?  
 No  Yes \_\_\_\_\_

Please list any hair products you use frequently: \_\_\_\_\_

**Laboratory details only**

Received at Lab by:	Date received:
Seal intact? <input type="checkbox"/> No <input type="checkbox"/> Yes	Documentation checked: