uchealth

List of Direct Laboratory Services

LABORATORY SERVICES | No appointment necessary

INDIVIDUAL TESTING MENU			Check box to order test	INDIVIDUAL TESTING MENU			Check box to order test
Basic Metabolic Panel	LAB15	$20		Iron Panel	LAB4016	$20	
B12	LAB67	$20		Renal Panel Kidney Function	LAB19	$20	
Blood Typing (ABO/RH)	LAB895	$20		Lipid Panel 8-10 hour fast recommended	LAB18	$15	
CBC with Diff	LAB210	$18		Hepatic Function Panel Liver Function	LAB20	$20	
Cholesterol 8-10 hour fast recommended	LAB60	$10		Mumps IgG	LAB160	$25	
Comprehensive Metabolic Panel	LAB17	$25		Pregnancy, Serum, Quant	LAB3451	$25	
CRP	LAB149	$20		Pregnancy, Urine, Qual	LAB437	$20	
Drugs of Abuse	LAB3289	$30		Progesterone	LAB529	$29	
Electrolyte Panel	LAB16	$15		Prolactin	LAB531	$30	
Estradiol	LAB523	$29		Protime/INR	LAB320	$15	
Ferritin	LAB68	$25		PSA	LAB8010	$29	
Folic Acid	LAB69	$20		Rubella IgG	LAB496	$25	
Free T3	LAB137	$30		Rubeola IgG Measles IgG	LAB657	$25	
Free T4	LAB127	$30		Testosterone, Total	LAB124	$40	
Glucose 8-10 hour fast recommended	LAB82	$7		TSH	LAB129	$29	
Hemoglobin A1C	LAB90	$20		Urinalysis Dip w/ reflex to Microscopic if indicated	LAB347	$20	
Hepatitis B Surface Antibody	LAB472	$25		Varicella IgG	LAB162	$25	
Health Fair Panel Includes: CBC without differential, Comprehensive Metabolic Panel, Lipid Panel	LAB8801	$45		Vitamin D, Hydroxy	LAB535	$40	

uchealth

Direct Access Laboratory Testing Consent Form

LABORATORY SERVICES

Consent for Treatment/Payment/Receipt of Results

This is to certify that I consent to and authorize UCHealth Yampa Valley Medical Center to collect my blood and/or urine for analysis of the marked Direct Access Laboratory Testing. Direct Access Testing (DAT) is patient initiated testing that does not require a physician's order. I authorize UCHealth to release my results to me through the method indicated on this form. I understand that the UCHealth laboratory is not acting as my doctor, that this does not replace treatment by a physician and that I assume complete and full responsibility to take appropriate action with regard to test results, up to and including consulting with a physician. In this regard, I do not and will not hold the UCHealth laboratory responsible for my test results and absolve them and their affiliates of any liability. **I agree that I will seek medical advice, care and treatment from my usual source of health care if I have questions or concerns, have any symptoms of illness, or become ill.** I understand that the venipuncture process involves a small medical risk and may result in bruising around the area from which the blood is taken. In the event of an accidental needle puncture to the UCHealth staff member involved in the blood collection process, I consent to any routine blood test deemed necessary for the safety of the phlebotomist. As with laboratory testing of any nature, the potential for falsely elevated, lowered, positive or negative laboratory values is present.

I agree to take full financial responsibility for the tests requested and I understand that payment is required prior to specimen collection. I understand that the DAT I am requesting on the attached form will not be billed to a third party by UCHealth and that results will not be sent to a physician or healthcare provider, though the results will be available for review in my medical record. Should my provider review my results and request additional tests on the specimens collected by DAT, these add-on tests will be billed as physician-ordered tests and my insurance company may be billed for the additional tests only. If add-on tests are requested by my provider, please bill as follows (initial only one option):

_____ Bill me.

_____ Bill my insurance (A copy of your insurance information is required).

I understand the cost of DAT may increase in the future without prior notice. I understand that medical insurance generally does not cover the cost of DAT and usually will not reimburse these charges or apply them towards a deductible when they are not ordered by a physician. I accept full responsibility for inquiring with my insurer in this regard. I understand that additional tests may be performed if requested by my physician and those tests will be billed as I have indicated above.

Please select the method you prefer to receive your results:

- ☐ Access results via My Health Connection.
- ☐ Mail a copy of my results. (Request an envelope from the front desk and self-address it).

Print name: _____ Date of birth: _____
Last First

Patient signature: _____

Date: _____ Phone number for emergent/critical lab results: _____

If patient is under the age of 18, parent/guardian signature: _____