

DIRECT ACCESS TESTING ORDER FORM

Date of Service _____

PLEASE PRINT INFORMATION:

Name _____ Social Security No. _____
Address: _____ Date of Birth _____
_____ Sex: M F
_____ Phone Number _____

Mark the Test that You Would Like Performed:

*(Must be fasting, 8 hours for glucose, 12 hours for triglycerides to get accurate results)

PROFILES:

{S45}	* Comprehensive Health Panel (Sodium, Potassium, Chloride, CO ₂ , Glucose, BUN, Creatinine, Calcium, Albumin, Protein, AST, ALT, Alk Phos, Bili) {CPT=80053}
{S35}	* Basic Health Panel (Sodium, Potassium, Chloride, CO ₂ , Glucose, BUN, Creatinine & Calcium) {CPT=80048}
{S40}	Liver Function Panel (AST, ALT, Alk.Phos, T & D Bilirubin, Albumin & Total Protein) {CPT=80076}
{S40}	* Kidney Function Panel (Albumin, Calcium, Creatinine, Glucose, Sodium, Potassium, Chloride, CO ₂ , BUN and phosphorus) {CPT=80069}
{S37}	Iron Profile (Iron, UIBC, TIBC, % Sat) {CPT=83540 + 83550}
{S50}	Thyroid profile (Free T4 & Ultrasensitive TSH) {CPT 84443 & 84439}

CARDIOVASCULAR RISK ASSESSMENT:

{S27}	* Lipid Profile (Total Cholesterol, *Triglycerides, HDL, LDL, VLDL and cardiac risk) {CPT=80061}
{S25}	C-Reactive Protein, high sensitivity: {CPT = 86141}
{S15}	Cholesterol {CPT = 82465}

COMMON TESTS:

{S40}	Testosterone (adult male only) {CPT = 84403}	{S47}	PSA Screening (Prostatic Specific Antigen) {CPT = 84153}
{S15}	*Glucose {CPT = 82947}	{S25}	Pregnancy Test (serum) {CPT 84703}
{S27}	Hemoglobin A1c {CPT = 83036}	{S27}	CBC (complete blood & platelet count) {CPT = 85025}
{S35}	Ferritin {CPT = 82728}	{S20}	Blood type (ABO & Rh) {CPT = 86900} + {CPT = 86901}
{S15}	Potassium {CPT = 84132}	{S30}	Microalbumin {CPT = 82043}
{S43}	Vitamin D, 25-Hydroxy {CPT = 82306}	{S20}	Urinalysis, reflex microscopic if indicated {CPT = 81003} {reflex CPT = 81015}
{S20}	Magnesium {CPT = 83735}		

\$_____ Total (Payment must be made at the Outpatient Registration area prior to specimen collection)

Results will be available via Follow My Health (Patient Portal)

-Not a member of Follow My Health? Please provide your email here to get an invite to join: _____

☐ Please check if you require a copy of your results to be mailed to you. It will take up to 1-2 weeks to receive via mail.

Consent for treatment/payment:

This is to certify that I consent to and authorize the performance of specimen collection and analysis of the above marked laboratory tests. I understand that GLHS/NVML is not acting as my doctor and that I have sole responsibility to take appropriate action on the test results and consult my doctor regarding all abnormal test results. I agree to take full financial responsibility for the cost of the tests that I request and that payment will be required prior to specimen collection. I understand that these tests will not be billed to a third party by GLHS and no results will be sent to any physician or health care provider. I understand the cost of these tests may increase without prior notice. I understand that these test results will be included in the complete medical record chart kept at Grand Lake Health System and may be viewable by my healthcare provider.

Patient's signature

Date

HIS Label Here

Employee's signature

Date

LIS Label Here