



List of Direct Laboratory Services

Valid until 6/30/2026

Are you an **Aspen Club** member? ☐ Yes ☐ No

*Attention Lab Staff: If the patient is an Aspen Club member, change draw type to "Aspen Club". If not, change draw type to "DAT".

Payment is due Prior to service. Billing cannot be changed after service.

Individual Testing Menu			Check here to order
Basic Metabolic Panel	LAB15	\$25	<input type="checkbox"/>
Blood Typing (ABO/Rh)	LAB895	\$21	<input type="checkbox"/>
CBC with Diff	LAB210	\$21	<input type="checkbox"/>
Cholesterol (8–10 hour fast recommended)	LAB60	\$13	<input type="checkbox"/>
Comprehensive Metabolic Panel	LAB17	\$30	<input type="checkbox"/>
CRP	LAB149	\$21	<input type="checkbox"/>
Electrolyte Panel	LAB16	\$21	<input type="checkbox"/>
Estradiol	LAB523	\$73	<input type="checkbox"/>
Ferritin	LAB68	\$37	<input type="checkbox"/>
Folic Acid	LAB69	\$39	<input type="checkbox"/>
Free T3	LAB137	\$47	<input type="checkbox"/>
Free T4	LAB127	\$32	<input type="checkbox"/>
FSH	LAB86	\$52	<input type="checkbox"/>
Glucose (8–10 hour fast recommended)	LAB82	\$11	<input type="checkbox"/>
Group A Strep PCR	LAB8664	\$94	<input type="checkbox"/>
Hemoglobin A1C	LAB90	\$26	<input type="checkbox"/>
Hepatic Function Panel Liver function Test	LAB20	\$23	<input type="checkbox"/>
Heterophile AB Screen (Mono)	LAB482	\$16	<input type="checkbox"/>
Iron Panel	LAB4016	\$51	<input type="checkbox"/>
Lipid Panel	LAB18	\$32	<input type="checkbox"/>

Individual Testing Menu			Check here to order
Luteinizing Hormone (LH)	LAB87	\$52	<input type="checkbox"/>
Mumps IgG Ab	LAB160	\$30	<input type="checkbox"/>
Pregnancy, Urine Qual	LAB437	\$26	<input type="checkbox"/>
Pregnancy, Serum Quant	LAB3451	\$40	<input type="checkbox"/>
Progesterone	LAB529	\$56	<input type="checkbox"/>
Prolactin	LAB531	\$52	<input type="checkbox"/>
Protime/INR	LAB320	\$16	<input type="checkbox"/>
PSA	LAB8010	\$50	<input type="checkbox"/>
Renal Panel (Kidney Function)	LAB19	\$26	<input type="checkbox"/>
Rubella IgG Ab	LAB496	\$30	<input type="checkbox"/>
Rubeola (Measles) IgG Ab	LAB657	\$30	<input type="checkbox"/>
Sedimentation Rated, Automated	LAB322	\$11	<input type="checkbox"/>
Testosterone, Females/Child	LAB5803	\$68	<input type="checkbox"/>
Testosterone, Total	LAB124	\$68	<input type="checkbox"/>
Triiodothyronine (Total T3)	LAB136	\$42	<input type="checkbox"/>
TSH	LAB129	\$44	<input type="checkbox"/>
Urinalysis	LAB347	\$21	<input type="checkbox"/>
Varicella Zoster (VZV) IgG Ab	LAB162	\$30	<input type="checkbox"/>
Vitamin B12	LAB67	\$40	<input type="checkbox"/>
Vitamin D, 25 - Hydroxy	LAB535	\$68	<input type="checkbox"/>

Only valid at the following UCHealth locations:

UCHealth Laboratory – Broomfield Hospital

1820 Destination Dr.
Broomfield, CO 80021

UCHealth Laboratory – Garfield

1025 Garfield St., Suite C
Fort Collins, CO 80525

UCHealth Laboratory – Greeley Hospital

6767 W. 29th St.
Greeley CO 80634

UCHealth Laboratory – Harmony Campus

4630 Snow Mesa Dr.
Fort Collins, CO 80528

UCHealth Laboratory – Longs Peak Medical Center

1760 E Ken Pratt Blvd.
Longmont, CO 80504

UCHealth Laboratory – Medical Center of the Rockies

2500 Rocky Mountain Ave.
Loveland, CO 80538

UCHealth Laboratory – Poudre Valley Hospital

1024 S. Lemay Ave.
Fort Collins, CO 80524

UCHealth Laboratory – West Greeley

6906 10th St.
Greeley, CO 80634

UCHealth Laboratory – Windsor

1455 Main St., Suite 130
Windsor, CO 80550

UCHealth Laboratory – Yampa Valley Medical Center

1024 Central Park Dr.
Steamboat Springs, CO 80487





Laboratory – Yampa Valley Medical Center
Direct Access Laboratory Testing Consent

Patient Identification Label

Name	_____
MRN	_____
DOB	_____
Date of service	_____

Consent for Treatment/Payment/Receipt of Results

This is to certify that I consent to and authorize (facility) _____ 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 My Health Connection Patient Portal. 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 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 my results will not be sent to a physician or health care 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 (choose one option):

_____ Bill me.

Initial here if selected.

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

Initial here if selected.

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.

I will access my results via UCHealth's My Health Connection patient portal.

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.

Name of patient (printed)

Date of birth

Signature of patient or legally authorized representative (if under age of 18)

Phone number for emergent/critical lab results

Relationship to patient

Date

Time

CERTIFICATION OF INTERPRETER SERVICES

Provider must check mark this section if an interpreter is used to be a valid consent.

☐ Certification of Interpreter Services (if the patient's preferred language for health care is not English). I have communicated the information on this form and any explanations to the patient using a qualified Medical Interpreter in the patient's preferred language, or by speaking to the patient as a Qualified Bilingual Provider.

