

# List of Direct Laboratory Services

Appointments are required.

Individual Testing Menu			Check here to order
Basic Metabolic Panel	LAB15	\$20	<input type="checkbox"/>
B12	LAB67	\$20	<input type="checkbox"/>
Blood Typing (ABO/Rh)	LAB895	\$20	<input type="checkbox"/>
CBC with Diff	LAB210	\$18	<input type="checkbox"/>
Cholesterol (8–10 hour fast recommended)	LAB60	\$10	<input type="checkbox"/>
Comprehensive Metabolic Panel	LAB17	\$25	<input type="checkbox"/>
CRP	LAB149	\$20	<input type="checkbox"/>
Electrolyte Panel	LAB16	\$15	<input type="checkbox"/>
Estradiol	LAB523	\$29	<input type="checkbox"/>
Ferritin	LAB68	\$25	<input type="checkbox"/>
Folic Acid	LAB69	\$20	<input type="checkbox"/>
Free T3	LAB137	\$30	<input type="checkbox"/>
Free T4	LAB127	\$30	<input type="checkbox"/>
Glucose (8–10 hour fast recommended)	LAB82	\$7	<input type="checkbox"/>
Hemoglobin A1C	LAB90	\$20	<input type="checkbox"/>
Hepatitis B Surface Antibody	LAB472	\$25	<input type="checkbox"/>
Health Fair Panel (Includes CBC without Differential, Comprehensive Metabolic Panel, Lipid Panel)	LAB8801	\$45	<input type="checkbox"/>

Individual Testing Menu			Check here to order
Iron Panel	LAB4016	\$20	<input type="checkbox"/>
Renal Panel (Kidney function)	LAB19	\$20	<input type="checkbox"/>
Lipid Panel (8–10 hour fast recommended)	LAB18	\$15	<input type="checkbox"/>
Hepatic Function Panel (Liver function)	LAB20	\$20	<input type="checkbox"/>
Mumps IgG	LAB160	\$25	<input type="checkbox"/>
Pregnancy, Serum Quant	LAB3451	\$25	<input type="checkbox"/>
Pregnancy, Urine Qual	LAB437	\$20	<input type="checkbox"/>
Progesterone	LAB529	\$29	<input type="checkbox"/>
Prolactin	LAB531	\$30	<input type="checkbox"/>
Protime/INR	LAB320	\$15	<input type="checkbox"/>
PSA	LAB8010	\$29	<input type="checkbox"/>
Rubella IgG	LAB496	\$25	<input type="checkbox"/>
Rubeola IgG (Measles IgG)	LAB657	\$25	<input type="checkbox"/>
Testosterone, Total (Females & children)	LAB5803	\$40	<input type="checkbox"/>
Testosterone, Total (Males only)	LAB124	\$40	<input type="checkbox"/>
TSH	LAB129	\$29	<input type="checkbox"/>
Urinalysis (Dip w/reflex to Microscopic, if indicated)	LAB347	\$20	<input type="checkbox"/>
Varicella IgG	LAB162	\$25	<input type="checkbox"/>
Vitamin D, Hydroxy	LAB535	\$40	<input type="checkbox"/>

## UCHealth Laboratory – Yampa Valley Medical Center

1024 Central Park Dr., Steamboat Springs, CO 80487  
970.871.2350

Hours: Monday–Friday, 7 a.m.–6:30 p.m., Saturday–Sunday 8 a.m.–4 p.m.



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 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 Direct Access Testing 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 (initial one option only):

\_\_\_\_\_ 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.)

\_\_\_\_\_  
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