



1200 College Drive Rock Springs, WY 82901  
 307-362-3711  
 Tax ID – 83-6000295

**Patient Directed Testing (every Tuesday & Wednesday)**

Name \_\_\_\_\_ DOB \_\_\_\_\_ Male  Female   
Last First MI  
 Mailing Address \_\_\_\_\_  
 Phone \_\_\_\_\_ Hours Fasting \_\_\_\_\_ Email \_\_\_\_\_

An 8-hour fast is recommended for Glucose, Lipid and Iron Studies. Results available online through the MHSC HealthLife Patient Portal. If a paper copy is required, fill out a self-addressed envelope.

**Wellness Testing Participant:** Payment will be collected at the time of service. Reimbursement by your Insurance Company is at their discretion.  
**Insurance Provider:** Screenings performed by MHSC for your insured client were paid for in full at time and date of service on this order form.  
 (Diagnostic code Z00.00) **Reimbursement should go directly to your insured client.**

Blood Type w/RH	86900, 86901	\$ 20.00
CBC with Differential	85025	\$ 20.00
CBC w/o Differential	85027	\$ 8.00
Ferritin	82728	\$ 20.00
Folic Acid	82746	\$ 15.00
Glucose	82947	\$ 10.00
Hemoglobin A <sub>1</sub> C	83036	\$ 25.00
Hepatitis C	86803	\$ 25.00
HIV	86703	\$ 25.00
Iron Panel (Iron + TIBC)	83550, 83540	\$ 25.00
Infectious Mononucleosis	86308	\$ 15.00
Measles (Rubeola) IgG	86765	\$ 25.00
Potassium	84132	\$ 10.00
Prostate Specific Antigen (PSA)	84153	\$ 28.00
PT/INR	85610	\$ 15.00
Thyroid Stimulating Hormone (TSH)	84443	\$ 28.00
T4, Free	84439	\$ 20.00
Uric Acid	84550	\$ 15.00
Vitamin B12	82607	\$ 15.00
Vitamin D, 25-Hydroxy	82306	\$ 15.00
Estradiol (Adult male or children)	82670	\$ 40.00

Estradiol (female only)	82670	\$ 35.00
Estrogen w/Estradiol (female only)	82671	\$ 60.00
Progesterone (female only)	84144	\$ 40.00
Prolactin (female only)	84146	\$ 30.00
Testosterone (male only)	84403	\$ 25.00
Testosterone (Female, Children)	84403	\$ 35.00
<b>Throat Swab Tests</b>		
Flu A and B (DNA amplification)	87502	\$ 80.00
Strep A (DNA amplification)	87651	\$ 45.00
<b>Urine Test</b>		
GC/Chlamydia	87491, 87591	\$ 100.00
Pregnancy	81025	\$ 20.00
<b>Panels</b>		
Wellness Panel – CMP, Lipids, Uric	80053, 80061 84550	\$ 37.00
CMP (Comprehensive Metabolic Panel)	80053	\$ 25.00
BMP (Basic Metabolic Panel)	80048	\$ 20.00
Hepatic Function Panel (Do not order with CMP)	80076	\$ 20.00
Lipid Panel	80061	\$ 25.00
OB Panel w/HIV	80081	\$ 145.00
<b>TOTAL DUE:</b>		

Initials **CONSENT** I am aware of the possible risks associated with a venipuncture (blood draws) including but not limited to bruising, syncope, excessive bleeding and/or infection at the site of the draw. Having been advised of these risks, I consent to a venipuncture.

- I hereby request and grant permission to Memorial Hospital of Sweetwater County to draw blood from me for the purpose of performing laboratory tests.
- I request and authorize Memorial Hospital of Sweetwater County to obtain these laboratory results and forward them to me.

Initials **PHYSICIAN FOLLOW-UP:** I am aware that the Laboratory Medical Director will be notified in the event of a critical result. I am aware that the Laboratory Medical Director may contact me directly for critical results. I am responsible for contacting my primary care physician regarding all laboratory results obtained through Wellness Testing. I understand that lab tests are for screening purposes or monitoring disease. Lab tests are not intended to diagnose disease or predict illness.

Initials **NOTICE OF PRIVACY AND PATIENT RIGHTS:** I understand and have been provided with the Notice of Privacy Practices that explains my rights regarding the privacy and confidentiality of my patient health information and the Patient Bill of Rights regarding my rights as a patient.

**I have read and fully understand the above information and have been given the opportunity to ask questions. I acknowledge that I either have no questions or that my questions have been answered to my satisfaction.**

\_\_\_\_\_  
 Signature of Patient or Legal Representative Relationship to Patient Date

3 Copies: (1) Laboratory Copy (2) Patient Receipt/Copy (3) Admitting

