adams
MEMORIAL HOSPITAL
Member of Adams Health Network

1100 Mercer Avenue
P.O. Box 151
Decatur, IN 46733
p: 260 724 2145

DIRECT ACCESS TESTING (LAB) ORDER FORM

Personal Information (Please Print):

Name (*First, Last, MI*)______________________________Date of Birth____________Sex (M/F)_____

Address_________________________________City______________State_________Zip___________

Social Security Number (*SSN)*__________________Phone Number_____________________________

Select your test(s) from the list below: Tests in italics are included in the Chem 30.

*Fasting for 10-12 hours is recommended.

√	Laboratory Test	$$	√	Laboratory Test	$$
	Chem 30*	40		*Iron*	10
	Chem 30 + TSH*	55		Microalbumin/Creatinine Ratio	25
	CBC (Complete Blood Count)	25		Mumps IgG	25
	*Lipid Profile w/LDL**	25		Occult Blood, Stool	10
	Blood Type	20		Pregnancy Test, Serum	20
	*Cholesterol**	10		Pregnancy Test, Urine	15
	Covid-19 PCR (Cepheid)	100		PSA (Screening)	25
	Covid-19 Antigen (Binax)	35		Quantiferon TB	47
	CRP, high sensitivity	20		Rubella	25
	*Glucose**	10		Rubeola (Measles)	25
	Hemoglobin A1c	25		TSH	20
	Hepatitis B surface Antibody	25		Varicella Zoster IgG	25
	Homocysteine	35		Vitamin D, 25-OH	55
				Note: TB skin test (Mantoux) and 5 Panel Drug Screen are available through Corporate Medical Services Direct Access.	

Read and initial the following:

_____I understand that these tests are a screening tool and not designed to diagnose or predict illness. It is my responsibility to contact my physician for a professional interpretation of these results.

_____I understand that if I want a copy of these results to go to my physician that I am responsible for giving him/her a copy.

_____I understand that test results will be stored in my electronic medical record.

_____I understand that I must pay for these tests at the time of service.

_____I understand that my insurance cannot be billed for these tests. I will only receive a receipt of payment.

_____I understand that results will be mailed to the address I have provided within one week.

_____I have received or been offered the AMH Joint Notice of Privacy Practices.

Signature of Participant____Date________________________

Printed Name______________________________Relationship to Participant (if minor)______________

AMOUNT DUE________________ **PAYMENT ____Cash ____Check ____Credit Card ____HS**

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