JOINT TOWNSHIP DISTRICT MEMORIAL HOSPITAL™
AN AFFILIATE OF GRAND LAKE HEALTH SYSTEM

Tax ID #341623770

Date of Service _____
____ diagnostic
_____ preventative

DIRECT ACCESS TESTING ORDER FORM

*(This is the only valid DAT form as of **1/1/2014**)*

PLEASE PRINT INFORMATION:

Name_____ Social Security No._____
Address: _____ Date of Birth_____
_____ Sex: M F
_____ Phone Number _____

MARK THE TESTS THAT YOU WANT DONE:

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

PROFILES:

____ {$42} * Comprehensive Health Panel (lytes, Glucose, BUN, Creatinine, Calcium, Albumin, Protein, AST, ALT, Alk Phos, Bili) {CPT=80053}
____ {$32} * Basic Health Panel (Sodium, Potassium, Chloride, CO2, Glucose, BUN, Creatinine & Calcium) {CPT=80048}
____ {$37} Liver Function Panel (AST, ALT, Alk.Phos, T & D Bilirubin, Albumin & Total Protein) {CPT=80076}
____ {$37} *Kidney Function Panel (Albumin, Calcium, Creatinine, Glucose, electrolytes, BUN and phosphorus) {CPT=80069}
____ {$36} Iron Profile (Iron, UIBC, TIBC, % Sat) {CPT=83540 + 83550}
____ {$50} Thyroid profile (Free T4 & Ultrasensitive TSH) {CPT 84443 & 84439}

CARDIOVASCULAR RISK ASSESSMENT:

____ {$25} *Lipid Profile (Total Cholesterol, *Triglycerides, HDL, LDL, VLDL and cardiac risk) {CPT=80061}
____ {$24} C-Reactive Protein, high sensitivity: {CPT = 86141}
____ {$15} Cholesterol {CPT = 82465}

COMMON TESTS:

____ {$14} *Glucose {CPT = 82947}
____ {$25} Hemoglobin A1c {CPT = 83036}
____ {$13} Potassium {CPT = 84132}
____ {$24} Pregnancy Test (serum) {CPT 84703}
____ {$25} CBC (complete blood & platelet count) {CPT = 85025}
____ {$18} Blood type (ABO & Rh) {CPT = 86900} + {CPT = 86901}
____ {$18} Urinalysis, reflex microscopic if indicated {CPT = 81003} {reflex CPT = 81015}

_____ {$36} Testosterone (adult male only) {CPT = 84403}
_____ {$45} PSA (Prostatic Specific Antigen) {CPT = 84153}
_____ {$50} Blood Alcohol Level {CPT = 82055}
_____ {$33} Ferritin {CPT = 82728}
_____ [$40} Vitamin D, 25-Hydroxy {CPT = 82306}

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

Test Results:

- ☐ A copy of your results will be mailed to you within a week.
- ☐ A copy will be picked up from the Switchboard by (who)_____on (date)_____ (time)____

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.

_____ _____ _____ _____
Patient's signature Date Employee's signature Date