



PATIENT LABEL

DIRECT LAB TESTING REQUISITION

Best time Monday-Friday 7 am to Noon

	Multiphasic Profile (Includes**)	\$75.00	(\$15.00 savings)
	Chemistry Profile-DLT**	\$30.00	
	Fasting Lipid Panel-DLT**	\$15.00	
	Thyroid Profile-DLT**	\$25.00	
	CBC-DLT**	\$20.00	
	PSA-DLT	\$20.00	
	A1C-DLT	\$15.00	
	Vitamin D-DLT	\$30.00	
	Blood Typing-DLT	\$10.00	
	SARS-CoV-2 Antibody IgG II Test (For the detection of Antibodies to SARS-CoV-2 spike protein receptor binding domain)	\$42.00	

MAILING ADDRESS FOR YOUR RESULTS:

Street:		
City:	State:	Zip:
Phone: (Home)	(Cell)	(Work)

I understand test results will be mailed to the above address.

1. Test results will **not** be sent to a provider. A provider will not review results.
2. I understand that because the tests are not ordered by a physician, this testing is not eligible for insurance billing. I understand that these tests will **not** be submitted to any insurance company.
3. I understand that these test results will be included in the complete medical record chart at GCH.
4. Anyone under the age of 18 must be accompanied by a parent or guardian.
5. Additional copies of results may be obtained for this testing only, directly from the Lab without a release of information form.
6. I release and discharge GCH and its employees and contractors from any/and all liabilities arising from or relating to my failure to seek medical advice, follow-up testing and/or treatment or follow-up care following the receipt of these laboratory results.

Patient's Signature (or legal guardian if under 18 yrs)

Date

PATIENT ACCESS & LABORATORY USE ONLY:

Provider: Self Subtype: 35-DL Contract Code: Cash Patient Paid for Test(s) _____ (Initials)

- Paperclip copy of receipt to form and send with patient to Lab.

Note: A separate account is needed if the patient also has an order from a provider for additional tests or services.