



GUNNISON VALLEY HEALTH

ORDER FORM

ID LABEL - GVH STAFF TO COMPLETE

NAME

MRN

CSN

DOB

DOS

TIME: _____

Test Description	Price	Biotin Pause	Fasting Required	CPT	LAB CODES
☐ ABO Rh Blood Typing	\$60	✗	✗	86900, 86901	LAB 895
☐ Complete Blood Count (CBC w/ auto differential)	\$30	✗	✗	85025	LAB 1748
☐ Comprehensive Metabolic Panel (CMP)	\$43	✗	✗	80053	LAB 17
☐ C- Reactive Protein (CRP)	\$25	✗	✗	86140	LAB 149
☐ Estradiol	\$64	✓	✗	82670	LAB 523
☐ Ferritin	\$42	✓	✗	82728	LAB 68
☐ Folate	\$44	✓	✓	82746	LAB 69
☐ Follicle Stimulating Hormone (FSH)	\$55	✓	✗	83001	LAB 86
☐ Free T3	\$55	✓	✗	84481	LAB 137
☐ Free T4	\$40	✓	✗	84439	LAB 127
☐ Hepatitis C Ab	\$45	✗	✗	86803	LAB 868
☐ HGB A1C	\$38	✗	✗	83036	LAB 90
☐ Iron	\$31	✗	✗	83540	LAB 94
☐ Iron and TIBC	\$57	✗	✗	83540, 83550	LAB 6391
☐ Lipid Panel (Cholesterol, Triglyceride, High-density Lipoprotein)	\$39	✗	✓	80061	LAB 18
☐ Lipoprotein (a)	\$65	✗	✗	83695	LAB 563
☐ Low-density Lipoprotein (LDL)	\$27	✗	✓	83721	LAB 102
☐ Magnesium	\$28	✗	✗	83735	LAB 103
☐ Pregnancy, serum	\$20	✗	✗	84703	LAB 144
☐ Pregnancy, urine	\$20	✗	✗	84703	LAB 437
☐ Progesterone	\$45	✗	✗	84144	LAB 529
☐ Prostate Specific Antigen (PSA)	\$65	✓	✗	84153	LAB 3019
☐ Testosterone, Free and Total	\$65	✓	✗	84402, 84403	LAB 540
☐ Testosterone, Total	\$30	✓	✗	84403	LAB 5442
☐ Thyroperoxidase Antibodies	\$40	✓	✗	86376	LAB 5440
☐ Thyroid Stimulating Hormone (TSH)	\$39	✓	✗	84443	LAB 129
☐ Uric Acid	\$30	✗	✗	84550	LAB 141
☐ Urinalysis w/out microscopic	\$25	✗	✗	81003	LAB 553
☐ Vitamin B-12	\$43	✓	✗	82607	LAB 67
☐ Vitamin D (25-Hydroxy)	\$58	✓	✗	82306	LAB 535

The interpretation of the laboratory results of Direct Access Testing (DAT) should be left to your Licensed Clinical Provider. You are responsible for distributing your results to your provider and for scheduling a follow-up appointment with your provider. Test results outside the expected normal range may indicate the need to seek medical care from a Licensed Clinical Provider. Please reach out to Gunnison Valley Health Family Medicine Clinic for follow-up appointment if you do not have a Primary Care Provider at 970-642-8413.

**Direct Access Testing Consent**Consent for Treatment/Payment
/Receipt of Results

TIME: _____

ID LABEL - GVH STAFF TO COMPLETE

NAME

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DOS

This is to certify that I consent to and authorize Gunnison Valley Health/Gunnison Valley Hospital ("GVH") to collect my blood and/or urine for analysis of the selected Direct Access Testing ("DAT") tests. DAT is patient-initiated testing that does not require a physician's order. All DAT is performed under the oversight of the Gunnison Valley Health Laboratory Medical Director. I understand that GVH is not acting as my physician or healthcare provider, and that Direct Access Testing does not replace evaluation, diagnosis, treatment, or medical advice from a healthcare provider. DAT is not intended for the evaluation of emergency medical conditions. If I am experiencing chest pain, shortness of breath, stroke symptoms, severe bleeding, loss of consciousness, or another medical emergency, I understand that I should call 911 or seek immediate medical care. I understand that laboratory testing involves certain risks, including discomfort, bruising, bleeding, fainting, infection, specimen collection errors, and the possibility of falsely elevated, falsely decreased, positive, or negative laboratory results. If an accidental needle stick or other exposure occurs involving GVH personnel during specimen collection, I consent to any testing required to ensure the safety of the affected healthcare worker. I understand that some tests require specific preparation, including fasting or medication restrictions. Failure to follow preparation instructions may affect test accuracy and may require repeat testing.

I understand that my DAT results will become part of my medical record and may be accessible to authorized healthcare providers involved in my care. I understand that my results will not automatically be sent to a healthcare provider. I understand that normal laboratory results do not necessarily indicate the absence of disease or a medical condition. I understand that GVH will make reasonable efforts to contact me with critical results using the contact information provided but cannot guarantee successful contact if the information is incorrect, incomplete, outdated, or if you do not respond. I understand that abnormal/critical results may require prompt attention. Because results are not routinely provided to a clinician, I am responsible for reviewing my results and taking any follow-up actions; I deem appropriate. I understand that my health information will be maintained and disclosed in accordance with applicable privacy laws and the Gunnison Valley Health Notice of Privacy Practices.

I agree to take full financial responsibility for all tests requested. I understand that payment is required prior to specimen collection, and that DAT services are not billed to insurance, Medicare, Medicaid, or any third-party payer. I understand that health insurance plans generally do not reimburse for tests obtained without a provider order and that such charges may not apply toward deductibles or out-of-pocket expenses. I understand that published DAT prices are subject to change without notice.

DAT is generally limited to adults age 18 years and older. Exceptions may be made when a minor is legally authorized under Colorado law to consent to the healthcare service associated with the requested test.

Gunnison Valley Health may require documentation or verification of a minor's legal authority to consent prior to providing DAT.

Patient Acknowledgments - Please initial each statement:

- _____ I have read and understand the information provided above.
_____ I understand that these tests were not ordered by a healthcare provider.
_____ I understand that DAT does not replace medical evaluation, diagnosis, treatment, or preventive care.
_____ I understand that abnormal results may indicate the need for follow-up care, and that normal results do not guarantee the absence of disease.

Please select the method you prefer to receive your results:

- ☐ Access results via MyChart Patient Portal
☐ Fill out a Medical Records Request form – Phone (970) 641-7257, Fax (970) 641-7273
or email to: mr@gvh-colorado.org

Patient Name_____
Date of Birth_____
Patient Signature or legally authorized representative (if under the age of 18)_____
Phone (for emergent/critical lab results)_____
Relationship to the Patient (If not patient)_____
Date of Birth