Chase County Community Hospital
600 West 12th Street, Imperial, NE 69033 308-882-7111

DIRECT ACCESS TESTING REQUISITION

Participant Name: _____

Date of Birth: _____ Sex: _____M _____F

Address: _____ City, State, Zip _____

Phone (Home): _____ Phone (Cell): _____

WELLNESS PANELS	PRICE	PLEASE CHECK which tests you are requesting
General Health Panel – Includes General Chemistry, Uric Acid, Lipid Panel, CBC, and TSH *See individual test descriptions below	$75	
INDIVIDUAL TESTS	**PRICE**	
***General Chemistry** – 14-test panel which measures blood sugar, electrolytes, proteins, and overall kidney and liver function as well as uric acid	$25	
***Lipid Panel** – Triglycerides (fats and fatty substances), Cholesterol, HDL (good cholesterol), LDL (bad cholesterol) ***Please fast for 12-14 hours prior to test**	$25	
***CBC** – (Complete Blood Count)— Provides information about the types and amounts of cells in the blood, including WBC (white blood cell), RBC (red blood cell), HGB (hemoglobin), HCT (hematocrit), platelet	$20	
***TSH** – (Thyroid Stimulating Hormone) Used to evaluate thyroid gland function and monitor thyroid replacement therapy	$25	
Hemoglobin A1c – Used to diagnose diabetes and monitor blood sugar control in diabetic patients	$25	
PSA Screening – Prostate cancer screening, males only	$25	
Vitamin D – Used to evaluate bone health	$60	
Blood Type – ABO, Rh	$25	
Covid-19 Antibody – To determine immune status to Covid-19 virus	$50	
RADIOLOGY TESTS	**PRICE**	
Body Composition – Identifies lean muscle mass, bone and percentage of body fat	$40	
Payment: Cash_____ Check_____ Credit_____ **TOTAL COST**		

_____**Please mail my results to the address listed above** _____**I will pick up my results at CCCH within 3 days**

_____**I give permission to** _____ **to pick up/receive my results**

PARTICIPANT INFORMED CONSENT

- I understand that because these test results have not been ordered as a result of my personal medical condition, they are not considered a "covered service" for purposes of insurance, and that it will be my personal responsibility to pay for this testing.
- I also understand that the test results will not be maintained under my medical record number, and that the only copy will be mailed to me at the above address. **Copies are not kept in my medical record unless I make an appointment with my family provider and take a copy with me to my appointment. Results are only available at CCCH for 30 days past the date of testing.**
- I understand that no medical professional will review my test results and that the hospital will take no action based on the results.

_____ _____

Signature of participant or participant's personal representative Date

_____

Printed Name and Relationship to participant if signed by personal representative