Medina Healthcare System
Medina Regional Hospital & Clinics
DIRECT ACCESS TESTING
PAID AT TIME OF SERVICE-NO FURTHER DISCOUNTS.

PATIENT NAME: _____ **DATE: _____**
ADDRESS: _____ **PHONE #: _____**
_____ **Date of Birth_____**

TEST ORDERED	TEST NAME	COST
_____	ABO/Rh Blood Type	$21.00
_____	CBC (Complete Blood Count)	$21.00
_____	Total Cholesterol*	$16.00
_____	CMP (Comprehensive Metabolic Panel)*	$21.00
_____	Drugs of Abuse Screen (Urine Only)	$42.00
_____	Glucose **	$16.00
_____	Hemoglobin A1C (Glycated Hemoglobin)	$27.00
_____	Lipid Panel **	$31.00
_____	Mononucleosis Screen	$16.00
_____	HCG (Pregnancy Test)	$20.00
_____	PT/INR (Prothrombin Test)	$21.00
_____	PSA (Prostate-specific Antigen/Prostate Cancer Screening)	$37.00
_____	Strep. Screen	$21.00
_____	TSH (Thyroid Stimulating Hormone/Thyroid Function Test)	$37.00
_____	Urinalysis	$21.00
_____	General Health Screen (CBC, CMP, TSH) *	$41.00

PHYSICIAN IS #5 (SELF-REFERRAL) **TOTAL PAID=_____**
***Fasting recommended but not required**
****Fasting strongly recommended**

EMPLOYEE'S INITIAL: ____

Direct access testing is offering the individuals of the community a valuable service. Testing in the laboratory is performed by the standards set forth by the Clinical Improvements Act of 1988. Each patient receiving test results must understand the limitations of the test.

Test results are mailed to patients. In the event of a critical lab value, the patient will be notified by the laboratory staff via phone and referred to follow up with their primary care physician of record.

In addition, the primary care physician of record will receive the critical value report from the laboratory staff via telephone, fax or email.

Patients without a primary care physician will be referred to one of the following primary care providers: Dr. Matthew Windrow, Dr. Zachary Windrow, Dr. Miles Hutson, Dr. Richard Rowland, Dr. John Meyer or Dr. Robert Hayes, if the patient agrees to the physician referral. The patient must agree to be responsible for the results of the critical value and the outcome of the results after receiving the laboratory report.

Patient's Name (Print)_____

Patient's Signature _____ **Date Signed:** _____