LabCheck Program

Hours: 8:00 am – 4:50 pm, M-F

Date Mail:	Date Pick Up:
Tech:	

Please complete this form prior to your appointment and bring it with you.

First Name: _____   Last Name: _____

Address: _____

City: _____   State: _____   Zip: _____   Phone: _____

Date of Birth: _____/_____/_____   Gender: ☐ Male   ☐ Female

General Health

☐ Blood Type (500095) – $25

☐ Calcium (500186) – $10

☐ Cardiac Lipid/Cholesterol Panel (500408) – $28

☐ Chemistry Screen (500214) – $30

☐ Complete Blood Count (500195) – $20

☐ Ferritin (500300) – $22

☐ Folate (500305) – $22

☐ GGT (500318) – $10

☐ Hepatic Function Panel (500348) – $28

☐ High Sensitivity C-Reactive Protein (500228) – $30

☐ Iron (500392) – $18

☐ Iron Panel (500391) – $45

☐ Kit Fee (521233) – $40

☐ Magnesium (500417) – $15

☐ MMR Immunity (500431, 501269, 502293) – $60

☐ Mononucleosis (500042) – $20

General Health Continued

☐ Phosphorous (500465) – $15

☐ Uric Acid (500586) – $15

☐ Urinalysis (500652) – $20

☐ Vitamin B12 (500599) – $22

☐ Vitamin D 25 OH (500604) – $40

Diabetes Management

☐ Diabetes Screen (500322) – $15

☐ Hemoglobin A1c (500341) – $25

Thyroid Management

☐ Thyroid Screen (516734) – $35

☐ T3, Free (500541) – $28

Men's Health

☐ Prostate-Specific Antigen (520077) – $28

☐ Testosterone (501690) – $40

Women's Health

☐ Pregnancy Test, Serum (500333) – $25

Total Amount Due $ _____

LabCheck test results will be visible using the MyChart application. St. James Hospital Laboratory is not responsible for mailing or faxing *Labcheck* results to patient's care provider. Once results have been released to patient, it is the patient's responsibility to provide results to their care provider. All questions about results can be answered by St. James Medical Group providers at 406-496-3600.

I hereby authorize St. James Hospital *LabCheck* to complete the laboratory tests I have requested.

*****Must be at least 18 years of age**

_____   _____   _____
Patient Signature   Date   Time

_____   _____   _____
Witness Signature   Printed Name   Date   Time

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Place patient label here.
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LabCheck Program Authorization & Disclaimer

LabCheck Program Disclaimer

Having requested these specific laboratory test(s) I understand that:

- Laboratory results from St. James Hospital *LabCheck* are for informational purposes only and are not a substitute for medical advice, diagnosis or treatment.
- I am aware that I should consult a physician before I stop, start or change any treatment plan, including the use of medication.
- I am responsible for consulting a physician.
- Neither St. James Hospital *LabCheck* nor its employees will interpret the results for me.
- I understand that results within the normal range do not ensure health.
- I understand that results that fall outside the normal range may not indicate disease.
- I understand that lab tests are not a substitute for a full medical evaluation.

Please initial each statement below:

_____ I am 18 years of age or older.

_____ I will not hold St. James Hospital *LabCheck*, its Officers, Director, employees, affiliates and sponsors liable for any outcomes which may result from my participation in this testing option.

_____ If I have requested that my results be mailed to me at the address listed, I retain all responsibility should someone else at that address access these results. I have also provided a phone number at which I can be reached in the event that critical lab values are reported.

_____ I understand that I am expected to pay St. James Hospital *LabCheck* in full at the time of service, that no other billing will occur, and that there is no refund option available. If I am eligible to receive Medicare benefits, I am aware that Medicare does not cover this service and I am fully responsible for payment at this time.

I have read and understand the information provided to me in this disclaimer.

_____ _____ _____
Patient Signature   Date   Time

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LabCheck Program Authorization & Disclaimer

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