Midland Memorial Hospital, Midland, TX 79701
DIRECT ACCESS TEST REQUEST FORM

Name: ______________________________ Date: __________________________________
DOB: _______________________________ Address: _______________________________
Phone: ______________________________ City: __________________________________

SINGLE TESTS					
√		**Price**	√		**Price**
	CBC	*$15*		*Pregnancy, Urine*	*$15*
	Cardiac (Lipid) Panel	*$25*		*Partial Prothrombin Time (activated)*	*$10*
	Cholesterol Total	*$10*		*Prothrombin time w/INR*	*$10*
	CK Total	*$10*		*PSA Total*	*$30*
	CMP	*$20*		*Sedimentation Rate (ESR)*	*$10*
	Covid-SARS-2 IgG	*$50*		*T4 Free*	*$15*
	Covid-SARS-2 Total	*$50*		*T4 Total*	*$15*
	CRP	*$10*		*Quantiferon, TB Gold*	*$75*
	Direct Bilirubin	*$10*		*Testosterone Free*	*$50*
	Drug Screen, urine (no chain of custody)	*$70*		*Testosterone Total*	*$50*
	Folate, Serum	*$25*		*TSH*	*$30*
	Glucose	*$10*		*Uric Acid*	*$10*
	Hemoglobin A1C	*$20*		*Urinalysis*	*$10*
	Hepatic Panel	*$15*		*Vitamin B12*	*$25*
	Pregnancy, Serum	*$15*		*Vitamin D25 OH*	*$45*
PROFILE TESTING					
√		**Price**	√		**Price**
	Diabetes Profile: *Glucose, A1C*	*$25*		***Thyroid Profile:*** *T4 Free, TSH*	*$40*
	Universal Health Profile: *CBC, CMP*	*$30*		***Bariatric Vitamin Profile:*** *Vitamins A, K, B1, B6, C, E, D25 OH, B12 and Folate*	*$250*
	Wellness Profile: *CBC, CMP, T4 Free, TSH, Lipid, UA*	*$75*			

ALL RESULTS MUST BE PICKED UP BY THE PATIENT OR FAXED TO THE NUMBER YOU REQUEST. THE PATIENT MUST PROVIDE THE PHYSICIAN NAME AND FAX NUMBER. DUE TO PRIVACY ACT RESTRICTIONS, WE CANNOT RELEASE RESULTS TO ANYONE OTHER THAN THE PATIENT WITHOUT WRITTEN AUTHORIZATION BY THE PATIENT AT TIME OF COLLECTION. (See Below) RESULTS WILL NOT BE MAILED. A PHOTO ID WILL BE REQUIRED TO PICK UP RESULTS.

Midland Memorial Hospital Laboratory Consent and Notice Form

I, ______________________________, hereby give my permission to have the above testing performed without my primary physician's consent. I agree to pay in full for the test(s) at the time of service. I understand that if any of my results are out of the normal range, I should seek advice and/or treatment from my primary physician. By signing this consent, I understand that MMH Laboratory is released from all responsibility and I certify that I have received written notice of the MMH Health Information Privacy Practices (HIPPA) in pamphlet form.

Signature of patient or guardian: ____

FAX TO ____________________/____________________
(Fax number MUST be listed at time of service, results will not be faxed ANYTIME after)

Please allow ________________________________ (Print name) to pick up my results.