Roundup Memorial Healthcare
1202 3rd St. West Roundup, MT 59072
Phone: 406-323-2301
Lab Fax: 406-323-1170

RMH Direct Lab Order Form

Name (First, MI, Last)_____ Date of Birth: _____ Gender(M/F): _____
Address: _____City: _____ State: _____ Zip: _____
Phone #: _____

ALL DRAWING FEES INCLUDED WITH THE PRICE
MUST BE 18 YEARS OF AGE TO REQUEST TESTING

- ❖ Discount Pricing
- ❖ No Physician Order Needed
- ❖ No Need to Register
- ❖ Paid at Time of Service

I request the following laboratory tests and authorize Roundup Memorial Healthcare to complete these tests:

√	Laboratory Test	Cost
	Basic Metabolic Panel	$15
	Blood Type	$17
	CBC	$18
	CBC + Diff	$21
	Cholesterol*	$10
	Cholesterol Panel*	$30
	Comp. Metabolic Panel	$25
	Creatinine (Urine or Blood)	$15
	C-Reactive Protein (CRP)	$15
	FT3	$38
	FT4	$35
	Ferritin	$35

*10-12 hour fasting recommended

√	Laboratory Test	Cost
	Folate	$30
	Glucose	$10
	Hematocrit	$10
	Hemoglobin A1C	$24
	Iron	$18
	Iron Panel	$65
	Magnesium	$15
	Mono Test	$17
	PSA	$37
	Phosphorous	$13
	Pregnancy Test (Blood or Urine)	$20
	Sed Rate	$15

√	Laboratory Test	Cost
	TSH	$25
	Testosterone, Total	$50
	Uric Acid	$15
	Urinalysis	$18
	Urine Microalbumin	$15
	Urine Micro/Creat Ratio	$30
	5-part Urine Tox Screen	$50
	Vitamin D	$55
	Vitamin B12	$35
	Vitamin B12 + Folate	$55

Total Amount Due: $ _____

By requesting the above laboratory tests, I understand that:

- Laboratory results from RMH are **NOT** a substitute for medical advice, diagnosis, or treatment.
- It is solely my responsibility to promptly discuss all laboratory test results with a physician. Roundup Memorial Healthcare Laboratory will not provide interpretation, counseling, consultation, or care recommendation on the basis of any laboratory results provided to me.
- I should consult a physician before I stop, start, or change any treatment plan, including the use of medication.
- RMH is not responsible for initiating a visit with a physician.
- I understand that results within the normal range do not indicate absence of disease.
- I understand that results that fall outside the normal range do not indicate presence of disease.

Please initial each statement:

_____Laboratory results will be mailed to patient.
_____I shall pay RMH in full at the time of service. With these reduced price lab test fees, it shall be understood, no other billing will occur to any third party. I am aware that RMH will not submit any claims to my private insurance company. No refund is available if I am eligible to receive Medicare and/or Medicaid benefits. I am aware that Medicare and Medicaid do not cover this service and I am fully responsible for the payment at this time.
_____Notice of Privacy Practices (NOPP): My initials acknowledge receipt of the RMH NOPP.

SIGNATURE: _____ ***DATE:*** _____