Participants' Last Name (Please Print)	First Name	M.I.
Date of Birth	Male Female (please circle)	Phone Number
Address	City, State	Zip

Wray Community Direct Access Testing

*I hereby request and grant permission to Wray Hospital Laboratory services to perform laboratory screening tests, which may include obtaining a blood specimen via venipuncture or fingerstick. I request and authorize Wray Hospital laboratory services to obtain those screening results and mail them to me at the above address. I retain all responsibility should someone else at the mailing address I've provided access these results.

*I understand this testing should not be used as the only means to diagnose the existence or absence of any medical condition. I also understand that this testing is not a substitute for examination by a medical doctor, and that I alone am responsible for obtaining medical information or services from a doctor or other qualified healthcare provider.

*I understand that I am responsible for sending this information to my personal physician. Wray Hospital Laboratory is not proposing diagnosis or recommending medical treatment; but merely acting as a resource to provide me this additional medical information. I understand that should I become ill or have any complaints or questions regarding my health, I should contact my physician.

*In addition, I release all agents, employees and volunteer personnel involved in this health screening from any and all liability for the results of the testing/screening or any treatment I may receive from a physician of my choice based upon the information provided by this program.

*In accordance with State law, I understand Wray Hospital has a policy of testing patients for Hepatitis B, Hepatitis C and HIV (Aids) if an employee sustains a significant unexpected exposure to a patients' body fluids.

*I understand that I am expected to pay in full at the time of service. This service may not be reported to my insurance provider.

*I understand COVID Testing will be reported to the appropriate agencies to remain in compliance with State and Federal Regulations. WCDH care management team may contact patients regarding follow up care plans. Influenza A & B may be tested with COVID to comply with State and/or Federal Mandates.

I have read, understand and agree to the above provisions.

Participant Signature_____ **Date**_____

☐ **Yes—I would like these test results to become part of my Wray Hospital and Clinic medical record. I understand they will be included with information requested by insurance and/or health care facilities.**

Basic Metabolic Panel **Fasting Recommended**	**$18.00**		**COVID 19 IgG Antibody Test** Blood Test for Past Infection	**$85.00**	
Comprehensive Metabolic Panel* *Fasting Recommended**	**$30.00**		**PCR COVID TEST** For Travel & other Facility PreOP only ***Must be approved by: Care Manager Team	**$75.00**	
Lipid Panel **Fasting Recommended**	**$20.00**				
CBC (Complete Blood Count with differential)	**$20.00**				
TSH (Thyroid Stimulating Hormone)	**$20.00**		TB GOLD (Quantiferon)	**$90.00**	
PSA (Prostate Antigen Screen)	**$30.00**		Measles/Mumps/Rubella/Varciella Zoster Immunity	**$90.00**	
Serum Pregnancy Test (Qualitative)	**$15.00**		Total Due:		
Blood Type (ABO/Rh)	**$15.00**		Cash_____ Credit Card _____ Check _____ Additional Information:		
Fecal Occult Blood	**$20.00**				
Vitamin D, 25 Hydroxy, Total	**$65.00**				
Urine Drug Screen	**$45.00**		Collection		
Kit Collection Fee	**$20.00**		___/___/___ @ ___:___ By:		

amended 11/1/2022