Jackson County Regional Health Center Laboratory
Self-Ordered Test Requisition

Name: _____ Male or Female
Full Legal Name Circle One

Date of Birth: _____ SSN: _____

Address: _____
Street address City State Zip

Phone: _____

Each patient MUST list a good contact phone number and an accurate address in order to receive a copy of your results. Payment is due at the time of service. Cash, check, credit and debit cards accepted. Insurance will NOT be billed.

Check	Test Name:	Pricing
	Comprehensive Metabolic Panel (CMP)	**$35**
	Comprehensive Metabolic Panel (CMP) **& Magnesium**	**$40**
	Hemogram (CBC w/out the Diff)	**$30**
	Hemoglobin A1C	**$30**
	Lipid Panel **(12Hr. Fast)**	**$30**
	Prostate Specific Antigen (PSA) **(Males Only)**	**$50**
	Thyroid Stimulating Hormone (TSH) & Free Thyroxine 4 (FT4)	**$40**
	Vitamin-D 25Hydroxy	**$50**
	ABO/RH (Blood Type)	**$25**

12Hour Fast: Fast for 12 hours prior to blood collection; avoid caffeine products and alcohol. People who are fasting may drink water and take any medications with water on their normal schedule.

If you would like a copy of these results to be faxed to your Health Care Provider, list provider's name and fax number. Results will NOT be sent if left blank.

Health Care Provider Name: _____

Provider's FAX Number: _____

Consent Statement: EACH box must be initialed:

☐ I understand that Jackson County Regional Health Center (JCRHC) will provide the results of the laboratory test by mail directly to me. Tests are NOT provided to my health care provider unless the name and fax number are listed above.

☐ JCRHC is NOT responsible for providing treatment based on any result and I am responsible for seeking medical advice and assistance from my health care provider regarding my test results. I release JCRHC from any liability with respect to the test results provided.

☐ I understand that these results will be part of my Cerner Health Record.

Patient Signature: _____ Date: _____

What other test(s) would you like to see JCRHC offer?

Feb 2025