

Laboratory Services

301 Becker Avenue SW, Willmar, MN 56201

Phone: 320-231-4500 Fax: 320-231-4861 Please phone to schedule an appt.

www.centracare.com

CPT CODES

83540-83550-82728-84466 \$45.00

80048

80076

86765-86735-86762-86787-86706

80061

PRICE

\$25.00

\$25.00

\$100.00

\$35.00

Direct Laboratory Access Testing

○Testing Hours: Monday – Friday, 7:00 a.m. – 5:00 p.m. (excluding holidays)

PROFILES/PANELS

Basic Metabolic Panel
Liver Function (Hepatic) Panel

Iron Status Profile

Immune Status Profile

(Measles / Mumps / Rubella / Varicella)

Lipid Profile (With Calculated LDL)

(Iron / Iron Binding Capacity / % Saturation / Ferritin / Transferrin)

| | Last First | | мі | |
|--|--|----------------------|------|--|
| | | , | 1711 | |
| Addres | s: | | | |
| | | | | |
| City: | State: | Zip: | | |
| | | | | |
| SS#: | DOB: | Sex: <u>M F</u> | | |
| | | | | |
| Phone: | Phone #2: | | | |
| | EAD THE FOLLOWING INFORMATION | | | |
| > | ANYONE UNDER AGE 18 MUST BE ACCOMPANIED BY A | | | |
| | PARENT OR GUARDIAN. (with the exception of the following | | | |
| | tests: Pregnancy Test, Blood Alcohol, Breath Alcohol, Urine o Hair Drug Screen per MN Statute §144.343) | | | |
| | | | | |
| > | TESTS ARE BEING PERFORMED AT YOUR REQUEST. | | | |
| > | TESTING WILL NOT BE SUBMITTED TO YOUR INSURANCE. | | | |
| | RESULTS WILL NOT BE FORWARDED TO YOUR PHYSICIAN O FAXED. THEY WILL BE SENT DIRECTLY VIA MANNER YOU | | | |
| | | | | |
| _ | CHOOSE. YOU MAY SHARE AS DESIRED. | | | |
| ➤ IF ACTION ON RESULTS IS REQUIRED, I MUST CONTA | | | | |
| > | PHYSICIAN. | AVED DV A DATUOLOGIC | _ | |
| ~ | ABNORMAL RESULTS MAY BE REVIEWED BY A PATHOLOGIST. A LETTER OF EXPLANATION WILL BE INCLUDED IF NECESSARY. | | | |
| | A LETTER OF EXPLANATION WILL BE | INCLUDED IF NECESSAR | ۱۲. | |
| | | | | |
| Signature of Patient or Legal Guardian Date | | | | |

| THIS AREA FOR LABORATORY USE ONLY: | | | | |
|--|----------------------------|--|--|--|
| DLA - Order as Manual Req Entry in Beaker. | | | | |
| Specimen Conditions: | Collected by: | | | |
| Date Collected: | Time: | | | |
| Fasting? Yes No If | f yes, duration:Hrs | | | |
| Result Handling: Payment: | | | | |
| o Mail | o Credit/Debit Card | | | |
| Will Wait for Results | o Check # | | | |
| o Pick-Up | o Health Savings Acct Card | | | |
| Total Price: | | | | |
| Patient ID Labels | | | | |
| | | | | |
| | | | | |