ROCHESTER REGIONAL HEALTH Laboratories

Personal Health Self-Test Request

June 2017

Thank you for choosing Rochester Regional Health Laboratories. Please fill in the information below in order for us to process your test request in a timely and accurate manner. Most test results will be available within 24 hours, unless otherwise specified.

Last Name	First name	Middle initial

Sex Male Female	Date of birth	Phone number ( )-

Street Address	City, State, Zip	Have you eaten today? Yes __ No__ What time did you eat? AM PM

How do you want to receive your results? Mail to address on request: **Yes** **No**	Would you like a copy of the report sent to your physician? Yes No Signature below required for authorization.	Physician name and address

Method of payment: Amount $_____ Check ___ Charge ___ Type of card_____Exp. Date: /	Name on Card: _____ Account number: _____	

Test Menu

Please check mark the box next to the test you would like to order.

Specific Conditions

__ Glucose for blood sugar levels (Test #4306)	$20.00
__ Hemoglobin A1c (HB A1c) to monitor blood sugar (Test #4307)	$20.00
__ Pregnancy (Serum, Test #4309)	$25.00
__Pregnancy (Urine #4310)	$25.00

Heart Health - Heart Risk

__ Cholesterol (Test #4312)	$20.00

Drug Abuse

__ Screen to detect the presence of drugs (Test #4314)	$50.00

Cancer Screening

__Colorectal - Fecal Occult Blood X 3 (Test #4316)	$20.00

For internal use only.

Use (00099) as Attph/Req

Place Barcode label here

Disclaimer: This self-testing service provided by Rochester Regional Health Laboratories and GRIPA does not replace the diagnostic services and disease management provided by your doctor. You are urged to contact your doctor to follow-up and interpret your test results. A copy of the results can be sent to your doctor, if you wish. By signing this form you are giving us permission to send a copy of the test result to your physician if you have so indicated. If you do not have a doctor, you may contact GRIPA Care Management at 585-922-1520 or gripa.medical@rochesterregional.org for personalized help finding a physician who meets your needs. I certify that I am at least eighteen years of age, or am otherwise legally competent to make health related decisions for myself. I have read and understand the contents of this form, and by signing below; I agree to be bound by its contents and acknowledge receipt of ACM's privacy notice. *(Revised 06/09/2017)*

Print Name: _____ Signature: _____ Date: _____