TEST REQUISITION FORM

TOMORROW'S HEALTH
4309 W 27th Place, Suite 201
Kennewick, WA 99338
509-943-2174 (Office) | 509-940-0285 (Fax)
www.tomorrowshealth.net

Patient ID/Accession Number

FOR LABORATORY USE ONLY:	
Specimen Received: ❑ NP Swab ❑ Serum ❑ Plasma ❑ Whole Blood ❑ Saliva ❑ Urine ❑ Other Source _____ Collection Fee: ❑ $10 Saliva Specimen Fee: ❑ $5	Date Received:_____ Time____:_____ am/pm By:_____ Date Collected:_____ Time____:_____ am/pm By:_____

1) PATIENT INFORMATION:

Patient Name (Last, First, MI):_____ , _____ , _____

Address: Street_____City_____County_____State_____Zip_____

Date of Birth:_____ Sex/Gender: ☐ Male ☐ Female Cell Phone #:_____

Race: ☐ White ☐ Asian ☐ Alaska Native/American Indian ☐ Black/African American ☐ Hispanic/Latino ☐ Native Hawaiian/Other PI

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

2) BILLING INFORMATION:

☐ Insurance Billing:

Insurance Company Name:_____

Insurance Company Address:_____

Group Number:_____ Member ID:_____

Patient relation to policy holder: ☐ Self ☐ Spouse ☐ Dependent

Policy holder name (as listed):_____ D.O.B._____

☐ Self-Pay (Due at time of service): Cash or Card

*I acknowledge that insurance may not reimburse the cost of testing. _____
Initials

☐ Client Bill:

Client Name:_____

Client Contact Number:_____

3) ORDERING CLINICIAN:

Ordering Clinician: Type/Print Name:_____ Signature:_____

Company Name:_____

Address: Street_____City_____County_____State_____Zip_____

Phone #:_____ Fax #:_____ Email:_____

Physician ID#:_____ NPI #:_____

Test Results: ☐ Fax ☐ Email ☐ Electronic ☐ Mail/Hardcopy

Name:_____ Name:_____ Name:_____ Name:_____

DOB:_____ DOB:_____ DOB:_____ DOB:_____

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4) LABORATORY TEST ORDER:

COVID-19 Testing (see COVID-19 test information page):

☐ SARS-CoV-2 by RT-PCR	$80-85
☐ SARS-CoV-2 Ab (IgM+IgG)	$25

Test Panels:

☐ Anemia Panel	$65
☐ Anemia Panel Plus	$100
☐ Cardiovascular Disease (CVD) Risk Panel	$95
☐ Complete Blood Count (CBC) w/ Differential	$25
☐ Comprehensive Metabolic Panel (CMP)	$25
☐ Diabetes Panel	$35
☐ Diabetes Panel Plus	$50
☐ FSH and LH	$65
☐ General Health and Wellness Panel	$95
☐ Hepatic Function Panel	$25
☐ Hepatic Function Panel Plus	$35
☐ Lipid Panel	$30
☐ Men's Health Panel	$150-250
☐ PSA w/ Reflex to Prostate Health Index	$40-150
☐ Reproductive Health Panel	$200
☐ Testosterone, Free and Total	$85
☐ Thyroid Autoantibody Panel	$55
☐ Thyroid Function Panel	$75
☐ TSH w/ Reflex to FT3 and FT4	$35-75
☐ Urinalysis, Routine	$25
☐ Vitamin B12 and Folate	$55
☐ Women's Health	$250

Individual Tests:

☐ Albumin	$25
☐ Anti-Müllerian Hormone (AMH)	$35
☐ Apolipoprotein B (ApoB)	$40
☐ Beta-hCG, Quantitative	$35
☐ Bilirubin, Direct	$25
☐ Bilirubin, Total	$25
☐ Cortisol	$40
☐ C-Reactive Protein (CRP)	$25

Individual Tests (cont.):

☐ C-Reactive Protein, Highly Sensitive (hs-CRP)	$30
☐ DHEA-Sulfate (DHEA-S)	$45
☐ Estradiol	$50
☐ Fecal Occult Blood Test (FOBT)	$35
☐ Ferritin	$30
☐ Folate	$30
☐ Follicle-Stimulating Hormone (FSH)	$40
☐ Free Thyroxin (FT4)	$25
☐ Free Triiodothryonine (FT3)	$35
☐ Gamma Glutamyl Transpeptidase (GGT)	$25
☐ Glucose (Fasting)	$25
☐ Hemoglobin A1c (HbA1c)	$25
☐ Insulin	$30
☐ Iron	$25
☐ LDL, Direct	$25
☐ Luteinizing Hormone (LH)	$40
☐ Partial Thromboplastin Time (PTT) – coming soon	N/A
☐ Phosphorus	$25
☐ Progesterone	$40
☐ Prolactin	$40
☐ Prostate-Specific Antigen (PSA)	$40
☐ Protein, Total	$25
☐ Prothrombin Time (PT/INR) – coming soon	N/A
☐ Sex Hormone Binding Globulin (SHBG)	$45
☐ Testosterone, Total	$50
☐ Thyroglobulin Antibody (TgAb)	$30
☐ Thyroid Stimulating Hormone (TSH)	$35
☐ Thyroperoxidase Antibody (TPOAb)	$30
☐ Transferrin	$25
☐ Vitamin B12	$30
☐ Vitamin D	$50

☐ Other

Name:_____ Name:_____ Name:_____ Name:_____

DOB:_____ DOB:_____ DOB:_____ DOB:_____