Aspen Mountain Medical Center
4401 College Drive
Rock Springs, WY 82901
Phone # 307-352-6940
Fax # 307-352-6945
Tax Id 46-2887963
Wellness Testing Order Form
Jan 01, 2025 – Dec 31, 2025

New ____	**Active Women's Panel**	**CBC CMP Lipid TSH A1c CRP Iron Study Progesterone Testosterone F&T Estrogens DHEA-s Vit D Vit B12**	**$150**	Add	**CTP $65**	**JPP $65**
New ____	**Men's Essential Health Panel**	**CBC CMP Lipid TSH PSA A1c CRP Iron Study Uric Acid Testosterone F&T DHEA-s Estrogens Vit D Vit B12**	**$150**	Add	**CTP $65**	**JPP $65**
New ____	**Help My Hormones Panel**	**FSH LH Estrogens Testosterone F&T Progesterone DHEA-s**	**$150**	Add	**Prolactin $25**	
New ____	**Monthly Special**	**Test/Panel:**	**$ Varies**			
____	**Joint Pain Panel (JPP)**	**ANA RF ESR CRP Uric Acid CCP ASO**	**$75**			
____	**Complete Thyroid Panel (CTP)**	**TSH FT4 FT3 TT3 TT4 TPO Thyroglobulin Ab**	**$85**			
____	**Region 11 Respiratory Allergy Panel**	**See List**	**$220**			
____	**Food & Inhalants Allergy Panel**	**See List**	**$200**			
____	**Common Adult Food Allergy Panel**	**See List**	**$120**			
____	**Celiac Disease Reflex Panel**	**If screening test positive: Celiac specific testing is completed**	**$80**			
____	**General Health Panel**	**CBC CMP Lipid**	**$35**			
____	**A1c**		**$20**			
____	**TSH**		**$25**			
____	**PSA**		**$25**			
____	**Iron Studies**	**Iron TIBC %Sat Ferritin**	**$25**			
____	**Testosterone (Free & Total)**		**$25**			
____	**CRP**		**$25**			
____	**Vitamin D**		**$20**			
____	**Vitamin B12/Folate**		**$40**			
		Total:	**$**			

Name: _____ Date of Birth _____/_____/_____

Sex: ____ Email results to: _____

Mailing Address: _____

Phone #: _____-_____-_____

Physician: _____

I voluntarily participate in the Aspen Mountain Medical Center 2025 Wellness Testing. I understand I will receive a copy of my wellness testing results to the email/mailing address provided and a copy to my physician named above. I give Nyasha Bullock, MD and her affiliate's permission to contact me by phone with any of my results that are critical according to lab protocol. Ordered for the purpose of Wellness Testing, by Nyasha Bullock, MD (Wellness Testing Overseeing Physician).

Patient Signature: _____

(For Lab Use Only)
Date:
Time:
Initials: