SCH Health Fair Pre-Registration Form and Physician's Consent Form

Broadway Plaza, Suite 3&4, Sparta – Sat., January 25, 2020 (7:00-10:00 am)

PLEASE READ*

This Physician Order and Consent Form allows the below listed patient to receive any of the tests listed and checked below as desired by the patient at the 2020 Community Health Fair sponsored by Sparta Community Hospital. The results should be sent to physician's office and may be sent to the patient directly

Physician Signature (authorizing tests): _____ Date: _____

Primary Physician: _____Location: _____ If None, please check: ☐

PRE-REGISTRATION: ***Do not bring this form to the fair. It is for PREREGISTRATION ONLY and must be received by noon, Fri. Jan.24th.***

Preregistration payment must be received with this form. If payment not received, preregistration will not be processed. *Do not mail-in cash; however in person cash payment is accepted. Preregistration is requested, but not required. You may drop off form at the hospital admissions desk,* ***FAX: 618-443-1367,*** *mail to: Health Fair Screenings c/o Sparta Community Hospital 818 E. Broadway, Sparta IL 62286 or email to:* ***lewis.deborah@spartahospital.com.*** *Thank you, The 2020 Health Fair Committee.*

Last Name: _____ First Name: _____ MI: ____ Birth Date: ____ - ____ - _____

Mailing Address: _____ City: _____ State: _____ Zip: _____ Ph: _____

Gender: ☐ Male ☐ Female [email: _____]

2020 Voluntary Participation Consent Statement: *I want to participate in the Health Fair offered by Sparta Community Hospital. I understand my participation is completely voluntary.* **Blood Test:** *I authorize Sparta Community Hospital and its agents to obtain blood from me for the tests identified on this consent form and no others.* **Release of Results:** *I understand these results will be sent to the physician listed above and to me at the address provided above. If I have any questions about them, I understand that I should consult my personal physician. I understand these results will be made a permanent part of my medical record.* **General Release:** *I agree to release and hold harmless Sparta Community Hospital District and its respective agents or employees from any liability which may arise from my participation in this health risk assessment, except for injuries arising out of gross negligence or willful misconduct.*

☒	Test You Want	Description of the Test	Payment Required
☐	**Complete Blood Count** (CBC)	Shows the number of white and red blood cells, hematocrit, hemoglobin and platelets in your blood, as indicators of anemia, infection, internal bleeding or certain diseases and disorders.	$ 10.00
☐	**Comprehensive Metabolic Panel** (CMP)	**REQUIRES A 10 HR FAST**. A group of blood tests which check your body's electrolytes, blood sugar, proteins and how well the liver and kidneys are functioning.	$ 15.00
☐	**Lipid Panel**	**REQUIRES A 10 HR FAST**. Measures lipids; fats and fatty substances used as a source of energy for your body. Lipids include cholesterol, triglycerides, HDL and LDL	$ 15.00
☐	**Prostate Specific Antigen** (PSA)	**Prostate Specific Antigen** - **Men Only** - The doctor uses these results in conjunction with an exam to screen men for prostate cancer.	$ 20.00
☐	**Thyroid Stimulating Hormone** (TSH)	**Thyroid Stimulating Hormone** – This test measures the amount of TSH in your blood. TSH is produced by the pituitary gland. This test helps detect an over-active or under-active thyroid. (**Preferred for women**)	$ 20.00
☐	**Hemoglobin** A-1-C	**FOR THOSE WITH OR AT RISK FOR DIABETES**. A non-fasting diabetic test measuring blood sugar averages, which indicates if treatment measures are working to prevent organ damage.	$ 10.00

Patient Consent Signature: _____ Print Name: _____ **Date:** _____

PAYMENT OPTIONS: Cash, Check & Credit Cards Will Be Accepted At The Health Fair. ***No Cash with Mail-In PrePay.***

☐ PrePay – Amount: $_____ Cash/ Check #: _____ or Credit Card: ☐ Visa ☐ MC ☐ DISC ☐ AmExpress

Name (on Card): _____ Acct #: _____ Exp. Date: _____ SecCode:_____