REGISTRATION FOR BLOOD SCREENING

Name_____Birthdate_____ Age _____ M / F
(***Please Print Clearly***)

Address_____ Town/Zip_____ Phone_____

Health Care Provider Name _____ Address _____ Phone _____

Consent & Release Statement

The undersigned hereby requests that a Blood Screening be performed at the Bloomfield Health Department by Gentle Hands Mobile Phlebotomy Service and their affiliated lab for the fee stated below to cover the cost of the test.

I hereby release the Bloomfield Health Department, Gentle Hands Mobile Phlebotomy Service and their affiliated lab from any and all liability including any matter or thing committed or omitted which may arise during blood drawing or other examinations/tests or from the data derived therefrom:
It is understood that:

1. The data derived from such examination/tests is to be considered as preliminary and is in no way conclusive.
2. I agree to send a copy of the results to my health care provider.
3. The responsibility for initiating any follow-up for abnormalities identified lies with me as the person responsible for my own health.
4. I authorize the Bloomfield Health Department to inform my Healthcare Provider of these findings and speak to my HCP concerning the results my medical care.
5. The Bloomfield Health Department personnel will have access to my screening results for the sole purpose of encouraging follow-up for abnormal results.
6. No other individual or agency will have access to my individual screening results without express written permission from myself. Aggregate data may be used for report and research purposes.

Date _____ ***Signature*** _____

$3**5.00-Blood Screening (SMAC 23, Lipid, CBC w/diff, T4)**
$50.00-Blood Screening with PSA; PSA only-$35.00

Fee Paid – Cash_____; Check_____ Appointment Time (circle one): 8am 8:30am 9am 9:30am

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(Cut along dotted line and keep this portion for your records as a reminder of your appointment)

REGISTRATION FOR BLOOD SCREENING

Bloomfield Health Department Tuesday, April 25, 2017 8:30 AM – 10:00 AM

Name _____ Appointment Time _____

There is a minimum **TWELVE (12) hour fasting period** required for accurate measurement.
You may drink water during the twelve hours preceding your appointment.
If you take medication, please continue taking them as usual.

Bloomfield Health Dept., ATTN: Public Health Nursing, 1 Municipal Plaza – Lower Level, Bloomfield, NJ 07003
Phone: 973.680.4058; Email: nursing@bloomfieldtwpnj.com