Community Memorial Hospital
909 W 1st Street P.O. Box 148
Sumner, Iowa 50674
Ph: (563) 578-3275

PT Name_____
MR# _____
HAR #_____
DOB _____

WALK-IN WELLNESS LAB TESTING REQUEST & CONSENT FORM

Date of Service: _____CSN#_____
Participant Name (please print): _____
Address (Would you like results mailed: _____ Yes _____ No):
Street: _____
City: _____ State: _____ Zip code: _____
Phone Number: Cell: _____ Home: _____
Date Of Birth: _____/_____/_____ Female ☐ Male ☐
Primary Care Practitioner: _____

Please check which test(s) you want performed: (Areas are overlapping tests)

	Wellness Tests	Cost
FASTING	☐ **Comprehensive Metabolic Panel (COMPNL)**: sodium, potassium, chloride, bicarbonate, BUN, creatinine, calcium, glucose, alkaline phosphatase, AST, ALT, total bilirubin, total protein, albumin **Lipid Panel (LIPDLD)**: cholesterol, HDL, LDL, triglycerides, VLDL **Hemogram Complete Blood Count (CBCND)**: white blood count, red blood count, hemoglobin, hematocrit, MCV, MCHC, MCH, platelet count (fasting required)	$30.00
	☐ **Glucose (GLU)** (fasting required) – prediabetes and diabetes check ***PART OF CMP***	$10.00
NONFASTING	☐ **Hemogram Complete Blood Count (CBCND):** white blood count, red blood count, hemoglobin, hematocrit, MCV, MCHC, MCH, platelet count ***PART OF CMP***	$15.00
	☐ **Blood Type (ABORH)**: ABO, Rh	$15.00
	☐ **Hemoglobin A1C (GLYCO)**- Diabetes check	$25.00
	☐ **Prostate-Specific Antigen (PSA)** (PSA)	$25.00
	☐ **Thyroid Stimulating Hormone (TSH)(**TSH)	$20.00
	☐ **T4 Free (T4FRER)**	$15.00
	☐ **Vitamin D (25VITD)**- Bone health	$40.00
	☐ **Hepatitis C (HCVAB)**	$30.00

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Fasting requirements:
Participant needs to be fasting. This means nothing to eat or drink for 12 hours and no alcohol for 24 hours prior to blood collection. People who are fasting may have sips of water. Medications should be continued on normal schedule as directed by your healthcare provider.

1. I am requesting and granting permission for Community Memorial Hospital Laboratory ("CMH Lab") to perform the laboratory screening tests checked above, which may include obtaining a blood sample by venipuncture or capillary puncture.

2. I understand that the results of the screening test(s) will be mailed to me at the address that I have provided. I understand that I must address the envelope with my legal name, or I may be unable to receive results by mail. I may view my results through my personal My UnityPoint online account if I choose for my test results to be in the hospital medical record. I understand that I will be contacted by phone of any critical results that require immediate attention and that it is my responsibility to contact my provider regarding my test results, including critical results.

3. I understand that CMH Lab will include my test result(s) in my hospital medical record (or create a hospital record containing these results) unless I indicate that I wish to exclude these results from my hospital record. I further understand that CMH Lab may forward these test results if my provider's office requests a copy, and that this is for my treatment or care. My test results are confidential and subject to the Health Insurance Portability and Accountability Act (HIPAA).

   Please check which line applies:

   _____ I consent to CMH Lab including my test results in an existing or new hospital medical record.

   _____ I DO NOT CONSENT to CMH Lab including my test results in an existing or new hospital record, and request that these results are only shared with me.

4. I understand that payment for all testing must be made by me at the time of service. I further understand that the tests will not be billed to my insurance, Medicare, or other third party payors.

5. I understand that CMH Lab is not proposing a diagnosis, treatment, or offering medical advice by supplying these screening tests.

Signature Of Participant/Date: _____

Printed Name: _____ Relationship To Participant: _____

Privacy Notice Acknowledgement

_____ (initials) I have received or been offered a copy of the Community Memorial Hospital Notice of Privacy Practices.

Payment amount:	$
Payment type: _____ Cash _____ Check _____ Credit _____ Other: _____	
Receipt#:	By: