Community Special Services Consent Form

PLEASE present directly to the lab once completed.

1. Name: _____
Last First MI

2. Address: _____
Street City State Zip

3. Date of Birth ____/____/_____ **4. Hours Fasting** _____ **5. Daytime Phone:** _____

6. Primary Care Provider / Physician: _____ **7. Last 4 of Soc. Sec. #:** _____

8. Your email address: _____
May we send you updates/newsletters/announcements via email? ☐ Yes ☐ No

9. Tests: ☐ Package
Includes CMP, LIPID, A1C,
CBC, TSH, Covid-19 Antibody

☐ Vitamin D
☐ PSA

10. Your results will be posted to your FitzChart Patient Portal. Have you logged into your FitzChart Patient Portal before? ☐ Yes ☐ No

11. Race: _____ **12. Ethnicity:** _____

Consent and Release Statement

The undersigned hereby requests that health screening examinations/tests be performed by the organizations participating in the Health Fair under the direction of Fitzgibbon Hospital, Marshall, Missouri.

I hereby release the contributing organizations and Fitzgibbon Hospital from any and all liability including any matter or thing committed or omitted which may arise during blood drawing or other examinations/test or from the data derived therefrom.

It is understood that:

1. The results from such examinations/tests are to be considered as preliminary only and are in no way conclusive.

2. Health professionals will have access to my test results for the purpose of ascertaining if the results are abnormal and aiding me in initiating a follow-up exam.

3. The responsibility for initiating any follow-up examinations for abnormalities identified at the Health Fair lies with me as the person responsible for my own health and not with any participating organization.

_____ _____
Signature-Participant Date

Which one are you?

Check all that apply to receive more information on services that can help!

- ❒ **I do not have a primary care doctor and would like more information on selecting one.**
- ❒ **I am a woman over the age of 21 and would like information on testing for cervical cancer.**
- ❒ **Diabetes runs in my family, or I know my weight is more than I would like. I would like information on diabetes screening and prevention.**
- ❒ **I am over the age of 50 and have never had a screening colonoscopy. I would like to schedule my colon cancer screening or receive more information.**
- ❒ **I am a woman over the age of 40 or may be at higher risk for breast cancer because someone in my immediately family has been diagnosed with it. I would like to schedule my 3D Mammogram or receive more information.**
- ❒ **I am over age 55 and have a 30 pack/year* smoking history. With that history, I either currently smoke or have smoked in the last 15 years. I would like information or scheduling for low dose lung CT and the early detection of lung cancer.**
  ******Example of 30 pack/year history – 1 pack per day for 30 years, 2 packs per day for 15 years, 3 packs per day for 10 years.*
- ❒ **I am a man over the age of 50 and I smoke. I would like information on testing for Abdominal Aortic Aneurysm.**
- ❒ **I leak urine throughout the day or have pain or difficulty using the bathroom and would like information on Pelvic Floor Therapy.**
- ❒ **I have a family member or friend who is battling Alzheimer's or dementia and would like information on an Alzheimer's Support Group that meets in Marshall.**
- ❒ **I am struggling with grief over a loss, or I know someone who is grieving and would like information on grief support options in our area.**