COULEE MEDICAL CENTER

LAB FAIR

HEALTH SCREENING TESTING

SEPTEMBER 16TH – 20TH, 2024

7:00AM – 10:00AM

AT COULEE MEDICAL CENTER

-INSIDE THE MEDICAL ARTS BUILDING-

***Only for ages 18 and over**

Please do not eat or drink anything except water 12 hours prior to blood draw. Medications should be taken as usual.

- Test results will **NOT** be sent to your Provider.
- Test results will **ONLY** be mailed to the person at the mailing address listed on this form.
- If you wish for your provider to have the results, you will need to personally make an appointment with the provider to review your test results. You can call our scheduling department at (509)633-1753.

Please note: These tests ***do not*** replace an annual exam, please follow up with your provider.

Select the health screen(s) you would like to receive:

______ $40.00 **Comprehensive test profile** (Complete Metabolic Panel, Lipid Panel and CBC with Differential)

______ $20.00 **A1C**

______ $20.00 **TSH** (Thyroid Function)

______ $20.00 **Iron Panel** (Transferrin and Iron)

______ $20.00 **PSA Screen** (Prostate Cancer Detection [over 40 years of age])

Date of Birth____________________ **Age**_______ **Sex**_______ **Phone**___________________________

Name____
(First Name) (Middle Initial) (Last Name)

Mailing Address____
(Street/P.O. Box) (City) (State) (Zip Code)

Email____

LAB/ HEALTH FAIR

CONSENT TO HEALTH SCREENING AND WAIVER OF LIABILITY

1) **Consent to Participate**. I acknowledge and agree that I am voluntarily participating in Coulee Medical Center's health fair screening. My involvement is as a participant and not as a patient. I further acknowledge and understand that the screening is limited in nature and is not a substitute for seeking medical treatment or follow up with a health care provider.
2) **Consent for Blood/Body Fluid Testing; Risks**. I acknowledge and understand that by participating in the health screening, I will be required to submit blood and/or body fluid testing. I understand that I may experience slight pain or a bruise at the puncture site. There is also the risk of an accidental needle puncture or other biohazard exposure. In such a case, I authorize additional precautionary testing of the sample.
3) **Critical Values**. I acknowledge and understand that the on-call health care provider will have access to my test results for the purpose of ascertaining the results for any critical values and aiding me in initiating a follow-up exam or emergency visit. The responsibility for initiating any follow-up examinations or emergency treatment for critical values identified at the Health Fair lies with me as the person responsible for my own health and not with any participating organization or provider.
4) **No Health Care Provider/Patient Relationship.** With respect to my participation in the health screening, I acknowledge and understand that the on-call health care provider is not my personal health care provider and Coulee Medical Center is offering the screenings solely for my educational purposes. I understand that this means that I do not have a health care provider/patient relationship for purposes of the results of the screenings and I must contact my personal health care provider if I have additional questions or require follow up after the health fair.
5) **Preliminary Results**. I further acknowledge and understand that the screening results provided to me at the health fair are preliminary in nature and are in no way conclusive. I further understand that the screening is not diagnostic and it could fail to detect certain abnormalities that might be detected by more definitive screenings; or it might detect apparent abnormalities that would be found normal with more conclusive testing. For a conclusive medical diagnosis of any medical condition I may have, I understand that I need to be examined by my personal health care provider.
6) **Confidentiality.** I understand that Coulee Medical Center will maintain the confidentiality of the screening results in accordance with the hospital's Notice of Privacy Practices and applicable state and federal laws.

__________ Initials   I acknowledge that I have reviewed the Hospital's ***Notice of Privacy Practices.***

7) **Waiver and Release of Liability**. In exchange for being given free or low-cost health screenings, I release, discharge, and hold harmless, Coulee Medical Center, its employees, agents, officers, members, and health fair participating health care providers from any and all claims, demands, losses, damages, or injuries, arising from, or based in whole or in part on, my participation in Coulee Medical Center's health fair. This waiver and release of liability includes, but is not limited to, the results of the health fair screenings; any statements made to me by any health fair/lab agent, employee, or volunteer; nondisclosure to me of any information; or my receipt or non-receipt of any information from the health fair.

HEALTH FAIR PARTICIPANT ACKNOWLEDGMENT: I have read this form, or have had it read to me, and understand the contents of this form. I believe that I have the knowledge upon which to base consent to participate in Coulee Medical Center's health fair. All questions have been answered to my satisfaction. I hereby give consent to the screenings indicated on the Lab Fair order page.

____ ____ _______________

Participant printed Name **Participant Signature** **Date**