**2019**

**CMMC Annual Community Lab Screening**

**Registration/Consent**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Male\_\_\_\_ Female \_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consent: I authorize representatives of CMMC to collect, by venipuncture, a blood specimen for the purpose of analysis of

the following tests: **Please select the desired tests:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Mark  Appropriate  Tests | Date of Service | Place  Of  Service | CPT Code | ICD-10 | Charge | Tests | |
|  |  | 11 | 80053 | Z00.00 | $18 | | Complete Metabolic Panel |
|  |  | 11 | 80061 | Z00.00 | $20 | | Lipid Panel |
|  |  | 11 | 85027 | Z00.00 | $16 | | Hemogram |
|  |  | 11 | 84153 | Z00.00 | $35 | | PSA(Men Only) |
|  |  | 11 | 84443 | Z00.00 | $34 | | Thyroid Test (TSH) |
|  |  | 11 | 82306 | Z00.00 | $48 | | Vitamin D Total, 25-OH |
|  |  | 11 | 83036 | Z00.00 | $32 | | Hemoglobin A1C |
|  |  | 11 | 86803/87522 | Z00.00/Z72.89 | $40 | | Hepatitis C w/reflex if positive |
|  |  | 11 | 87806 | Z00.00/Z72.89 | $40 | | HIV (Human Immunodeficiency Virus) |

**For chemistry screens, please fast for 8-12 hours.**

**You may drink normal amounts of water.**

**Chemistry Screen**: Includes glucose, general electrolyte, liver and kidney function

**Lipid Panel**: Includes cholesterol

**Hemogram**: Screens for anemia, infection & leukemia’s

**Prostatic Specific Antigen (PSA)**: Prostate screen (MEN ONLY)

**Thyroid Stimulating Hormone (TSH)**: Thyroid Screen

**Vitamin D Total, 25-OH**: Screening for Vitamin D deficiency

**Hemoglobin A1C**: Average amount of sugar (glucose) in your blood over the past 2 to 3 months

**Hepatitis C W/Reflex**: Recommended for participants born between 1945 and 1965. A reflex test will be performed if the Hepatitis C result is positive.

**HIV 1/2:** The virus that causes AIDS. Transmitted through direct contact with HIV-infected body fluids, such as blood, semen, and vaginal fluids, or from a mother who has HIV to her child during pregnancy, labor and delivery, or breastfeeding.

I release the aforementioned persons performing such collection, analysis and reporting from any and all liability for injury or damage associated with the above procedures.

I accept all responsibility for seeking medical treatment from a healthcare provider of my choice in the event of abnormal laboratory results.

* **I understand that payment is due at the time of service.**
* **I understand that the CMMC lab will mail my results to me within 2 weeks of my lab draw.**
* **I understand that CMMC will NOT file my insurance, however I can submit these labs to my insurance.**
* **I understand that these results will NOT automatically be sent to my physician, but my physician may ask for my results to be sent to his/her office.**

**Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patients Representative:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship Date**

**Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**