***Please preregister by returning completed form to Memorial Hospital and Manor before 11/1/2023***

To Deborah Brown, via fax: 229-243-3340, deborahb@mh-m.org or you can drop-off your form to the Registration desks in the hospital’s front lobby or Emergency Department

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| **Memorial Hospital and Manor Wellness Screening Information Form** |
|  | COMMUNITY HEALTH FAIR | Health Fair Date: | 11/16/2023 |
| Name: | Last |  First | Middle | Date of Birth: |  |
|  |
| Social Security #: |  | Race: |  | Sex: |  |  |
| Mailing Address: |  |
| City, State, Zip: |  |
| Daytime Phone: |  | Evening Phone: |  |
| To receive and **view your results online** via your home computer or cell phone, please provide your email address: |  |
| Primary Care Physician: |  | Physician LocationCity, State |  |
| Testing:(check all that apply) |  Cholesterol; Glucose |  PSA screening (men age 50+ only) |
| I verify that I am:(choose one) |  **FASTING** | I **have not** eaten or drank anything for at least 8 hours |  **NON-FASTING** | I **have** eaten or drank something during the last 8 hours |
| I hereby consent to having my blood drawn for screening purposes for this health fair. In consideration of having this testing, I hereby release Memorial Hospital and Manor and any other organization(s) associated with this screening, their affiliates, directors, officers, employees, successors, and assigns from any and all liability arising from or in association with this screening or from data derived therefrom. I understand that:1) The data derived from this health fair or service is for screening purposes only, and does not constitute a diagnosis or treatment of any kind.2) If the results of the screening indicate a follow-up examination is necessary, the responsibility for obtaining a follow-up examination to confirm or review these results is mine alone, and not the responsibility of any organization(s) associated with this screening.3) I understand that this service is given to me as a health fair tool and as a benefit to me, and it is my responsibility to follow-up or arrange care with a Physician or Provider and to discuss the results of any testing performed during this health fair. |
| Signature: |  | Date: |  |
| **LABORATORY USE ONLY** |
| Collection Time: |  | Collected By, Initials and Date: |  |
| Wellness Profile= WELLP |  | Accession No |  |