

Spencer Hospital Community Health Services will be doing wellness screenings at the Spencer Family YMCA, Tuesday, February 14, 2012 from 7:00am – 9:00am. Pre-registration required.

The clinical screening will be performed by Spencer Hospital & Community Health staff.

Your clinical screen will include:

- ◆ **Height and Weight Check**
- ◆ **Body Composition Analysis**
- ◆ **Blood Pressure and Pulse Check**
- ◆ **Laboratory Blood Test Analysis:** Screens for diabetes, anemia, heart, liver, and kidney function with tests such as BUN, Creatinine, Alk phos, AST, ALT, Cholesterol, Triglycerides, HDL, LDL, Total Cholesterol/HDL Ratio, Hemoglobin, Hematocrit, WBC with diff., RBC and indices, Platelets, Electrolytes, and Glucose.
- ◆ **TOTAL: \$50.00**

All information will be kept completely confidential

Optional:

- ◆ **\$10 Thyroid (TSH)**
- ◆ **\$25 PSA** (blood test; prostate cancer screening for men)
- ◆ **\$2 Colorectal Cancer Screening Kit**
- ◆ **\$15 Personal Wellness Profile:** This is a *health risk assessment* assesses individual health status, estimates level of health risk, and provides feedback to motivate behavior change to reduce health risks.

WELLNESS PRESCREENING INSTRUCTIONS

- ◆ DO NOT eat or drink anything 12 hours before your appointment time.
 - *However, please take your prescribed medications with a minimal amount of water.*
- ◆ DO NOT exercise 12 hours before testing
- ◆ PLEASE wear socks / shoes that can easily be removed for the body composition analysis.

BRING YOUR COMPLETED REGISTRATION FORM WITH YOU TO YOUR APPOINTMENT

The screening should take approximately 15 minutes.



Care You Trust. From People You Know.

Wellness Screening Registration Form

If you have any questions, leave it blank and fill out with the nurse.

LAST FIRST MI ADDRESS APT # CITY, STATE, ZIP PHONE (H) (W) (C) E-MAIL

GENDER: MALE FEMALE AGE DATE OF BIRTH

PHYSICIAN PHONE ADDRESS CITY, STATE, ZIP

MEDICATIONS

OFFICE USE ONLY - TO BE COMPLETED BY STAFF

Table with 4 columns: HEIGHT, WEIGHT, LAB, FITNESS TEST VO2; BP, RESTING HR, KNOWN % FAT, CLASS; BMD, WAIST CIRCUM., BMI, TEST TIME; EXERCISE HR

I give my permission to the Spencer Hospital to perform screenings as listed on this form. I understand that my data will remain anonymous and may be included in a group report.

I, the undersigned, hereby voluntarily authorize Spencer Hospital and its employees to draw blood for the purpose of laboratory test analysis.

I understand that the laboratory blood test analysis results are confidential. I understand that I will receive the results of the wellness screening. Results will not be sent to my personal physician.

I also understand that this screening program does not provide absolute indicators of risk and that it is not meant to diagnose illness or disease, or provide a substitute for medical care.

I authorize Spencer Hospital to release my laboratory blood test analysis to my personal physician, if warranted. I understand and agree that it is fully my responsibility (not my physician's or Spencer Hospital's) to do the following:

- 1. To obtain any diagnosis of illness or disease from my physician
2. To make an appointment with my physician if I desire interpretation and discussion of any abnormal test results.

I CERTIFY THAT I FREELY CONSENT TO THESE LABORATORY BLOOD TESTS AND THAT I UNDERSTAND THIS DOCUMENT.

SIGNATURE OF PARTICIPANT DATE

SIGNATURE OF WITNESS DATE