PAULDING COUNTY HOSPITAL

Spring 2021

1. Mark the boxes below to indicate the health screening(s) that you are interested in receiving.
2. Complete the personal information and sign and date at the bottom
3. Return the form and payment ahead of time to Paulding County Hospital Cashier or bring the completed form and payment with you to the one of the Paulding County Hospital's Family Health Days.

To obtain accurate test results, fast for 10 to 12 hours. You may take normal medications and drink water.

❑ **Comprehensive Health Panel**: Glucose, BUN, Creatinine, Sodium, Potassium, Chloride,CO2, Calcium, Total Protein, Albumin, Globulin, A/G Ratio, Total Bilirubin, AST, ALT, Alk Phos, Cholesterol, Triglycerides, HDL, LDL, Chol/HDL Risk Factor, and Hemogram (Blood tests that check general metabolic health including possible problems for diabetes, risk factors for heart disease, nutrition status, liver, kidney, anemia, and blood count.)	$30.00
❑ **Thyroid Screen**: TSH – Thyroid Stimulating Hormone (Blood test that may determine malfunction of thyroid gland resulting in possible weight gain or loss, fatigue, insomnia, a feeling of being too hot or too cold.)	$15.00
❑ **Hemoglobin A1C**- Also referred to as Glycohemoglobin. Used to monitor compliance with diabetic treatment and commonly used as a diagnostic test for diabetes.	$15.00
❑ **PSA** – Prostatic Specific Antigen (A blood test to aid in the detection of prostatic cancer which is the second most common cancer in males. This test is recommended for all males over the age of 50- even earlier for males with family history.)	$20.00
❑ **Vitamin D –** Important for bone health, diabetes, multiple sclerosis, weight loss, heart disease, depressions, possibly even cancer	$20.00
❑ **Hepatitis C Virus (HCV) Screening –** If you were born between 1945 and 1965, you're 5 times more likely of having an unknown Hepatitis C infection. HCV infection can have little or no symptoms, but can lead to liver failure, liver cancer, and can be fatal if untreated. Additional information is available for other high-risk categories and on Acute and Chronic Hepatitis C infections.	$15.00
☐ **CASH** ☐ **Check#** _____ ☐ **Credit Card (Prepaid only)** **Total**	

First Name	Middle Initial	Last Name
Address	City	State and Zip Code
Phone Number	Male or Female	Date of Birth
Social Security Number	Select Date (M, T, TH 7:00 AM – 9:00 AM) (Saturday 7:00 AM – 10:00AM) **Monday Tuesday Thursday Saturday** **April 12 April 13 April 15 April 17**	

Results of these tests will not be sent to your physician; however, your results may be available to physicians via the electronic health record. Upon signing below, you have given permission for your results to be released to you and you understand that such data is not considered conclusive and not meant to supersede regularly scheduled medical exams. If you have any medical complaints, you should arrange a visit with your physician. As this is an invasive procedure, I agree to have my blood drawn. I understand the above information and I relinquish any responsibility to Paulding County Hospital and their employees.

Signature:_____Date:_____