YORK GENERAL

LABORATORY HEALTH SCREENINGS

Medical Laboratory Professionals Week
LABORATORY PROFESSIONALS GET RESULTS
April 19-25, 2026
#LABWEEK

- **CBC, CMP & LIPID PANEL** $45
- **HEMOGLOBIN A1C** $15
- **VITAMIN D** $40
- **PROSTATE SPECIFIC ANTIGEN (PSA)** $15
- **THYROID STIMULATING HORMONE (TSH)** $10
- **TESTOSTERONE** $20
- **FSH/LH PANEL** $35

Screenings available during ENTIRE MONTH of APRIL
by Appointment ONLY **call (402) 362 - 0439**
to schedule appointment. Bring completed form with you.
CASH or CHECK will be accepted on day of appointment. *NO CREDIT/DEBIT*

QUESTIONS? CONTACT LABORATORY DIRECTOR BILL BOLTE AT (402) 362 - 0439

Screenings will be done in the York General Laboratory at the hospital

YORK GENERAL

WELLNESS SCREENING REGISTRATION

LAB USE ONLY:
Spec Time: _____
Initial: _____

TODAY'S DATE: _____

PLEASE COMPLETE THE FOLLOWING (PLEASE PRINT):

NAME: _____ SEX: _____

ADDRESS: _____ CITY/ZIP _____

PHONE: _____ E-MAIL ADDRESS:

DATE OF BIRTH: _____ AGE: _____

SOCIAL SECURITY: _____

PRIMARY PHYSICIAN: _____

TESTS TO BE PERFORMED:

** 10 to 12 hour fast is recommended for ideal results from your lab tests**

___ $45 **Wellness blood profile** - includes CBC, CMP, and Lipid Profile, including testing for diabetes, cholesterol, liver function, anemia, and infection

___ $10 **Thyroid Stimulating Hormone (TSH) test** - measures how well your thyroid gland is working

___ $15 **Hemoglobin A_1C**- measures your average blood sugar over 3 months

___ $15 **(Men only) Prostate Specific Antigen (PSA) test** - checks for disease in the prostate

___ $40 **Vitamin D** – Determines the amount of this vitamin in your body used to help absorb dietary calcium from the intestine and to help regulate calcium in maintaining healthy bone structure.

___ $20 **Testosterone** – Sex hormone that promotes growth and development of male sexual organs, increases body mass and hair replacement. Also produced in women during menstrual cycle.

___ $35 **FSH/LH**– Female sex hormones associated with ovulation and useful in evaluating perimenopausal symptoms.

***** Participant results will be mailed along with definitions and normal values of the tests*****

NOTICE OF PRIVACY PRACTICES:

I have received and agree to the terms of the Notice of Privacy Practices of York General. I understand that my results will be kept confidential and will be mailed to only me.

Signature: _____ Date: _____

AUTHORIZATION FOR TREATMENT:

I, the undersigned, grant permission to the staff of York General Hospital Laboratory to collect a blood sample and perform the tests listed above. I understand that the results will not be reported to any physician unless there is a critical value.

Signature: _____ Date: _____