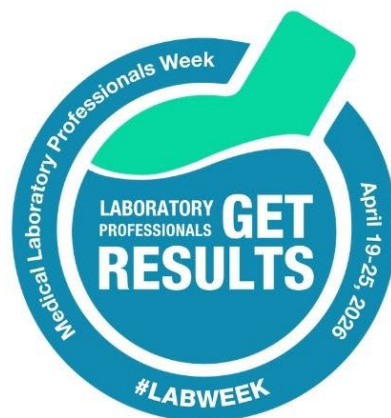




LABORATORY HEALTH SCREENINGS



- 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





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 A₁C** - 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: _____