

## 2004 Heart Month Cholesterol Testing

Please Print: Name: \_\_\_\_\_  
Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex: M F  
Social Security Number: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Daytime Phone: \_\_\_\_\_

Office Use:  
No. Hours fasting:  
\_\_\_\_\_  
Time of draw:  
\_\_\_\_\_

Choose One:  Total Cholesterol \$10  
 Cardiac Risk Panel (Cholesterol, HDL, LDL, VLDL, Triglycerides, Glucose) \$20

### CONSENT AND RELEASE FOR CHOLESTEROL SCREENING:

I hereby consent to the drawing of a blood sample for the purpose of measuring my blood cholesterol level or cardiac risk panel. In consideration for having my blood drawn for this sole purpose, I hereby release GRANDE RONDE HOSPITAL and HEALTH NETWORK FOR RURAL SCHOOLS, affiliates, directors, officers, employees, successors and assigns, from any and all liability arising from and in any way connected with this blood drawing for my cholesterol or cardiac risk measurement or from the data derived therefrom. I understand that:

- The data derived from this test is to be considered preliminary only and does not constitute a diagnosis of hypercholesterolemia.
- If the result of my cholesterol/cardiac risk panel measurement suggests that I may be at increased risk of heart disease according to the national Institutes of Health guidelines, I may make the results available to the physician of my choice.
- The responsibility for initiating a follow-up examination to confirm the results of this screening and obtain professional medical assistance is mine alone, and not that of any organization(s) associated with this screening.
- I will receive a copy of my results and one will be kept on file at the Grande Ronde Hospital.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

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