MAGRUDER HOSPITAL
It's How We Care

Health Screening Consent

Welcome to the Ottawa County Health Screening Program.

DESCRIPTION OF SERVICES OFFERED:

Chem Profile

The Chem Profile involves over 24 different blood tests performed on a single blood specimen that gives a wide spectrum analysis/profile of an individual's health status. The Chem Profile includes the following tests:

Glucose	Gamma GT	BUN	Alkaline Phosphatase
Creatinine	Total Bilirubin	Uric Acid	Iron
Sodium	Cholesterol	Potassium	Triglyceride
Chloride	HDL Cholesterol	Carbon Dioxide	Osmolality
Calcium	Albumin Globulin Ratio	Phosphorus	BUN/Creatinine Ratio
Total Protein	Coronary Heart Disease Risk 1	Albumin	LDL Cholesterol
LDH	Globulin	SGOT	Anion Gap
SGPT	eGFR		

These tests, both individually and in relationship to each other, reveal clinical data on such areas as blood sugar levels, kidney function, electrolyte balance, cholesterol and triglyceride levels, liver function, and iron levels. These tests produce results that are categorized as being in a normal range, or as being above or below normal. Two copies of the test results will be sent to you, and it is up to you to share and review them with your primary care physician.

The Chem Profile is a minimally invasive procedure (requires drawing approximately 6 ml of blood) and therefore requires the signing of a consent form prior to the specimen collection. **The Chem Profile also requires fasting for 12 hours prior to specimen collection. This fasting involves no oral intake except for water in the 12-hour span prior to the test.**

Prostate Specific Antigen (PSA)

The prostate is a walnut size gland situated below the bladder, posteriorly. It produces Prostate Specific Antigen (PSA). This antigen is able to be analyzed from a sample of approximately 7 ml of blood. The normal PSA value is less than 4.0 ng/ml.

Colorectal Disease Screen

Each participant electing this option will be given a colorectal screening kit to be used in the privacy of his or her home. This is a self-administered screen that utilizes a simple, clean method for checking for the presence of hidden blood in your stools. One of the primary warning signs of many colorectal diseases such as bleeding ulcers, colitis, fissures, diverticulitis, bleeding hemorrhoids, colorectal cancer, and others is hidden blood in the stool. This kit includes a pre-printed card whereby you record the results of your self-exam. This card should then be mailed to the physician of your choice.

IgG Antibody Screening

This test detects IgG antibodies that develop in most patients within seven to ten days after symptoms of COVID-19 begin. IgG antibodies remain in the blood after an infection has passed. These antibodies indicate that you may have had COVID-19 in the recent past and have developed antibodies that may protect you from future infection. It is unknown at this point how much protection antibodies might provide against reinfection.

CONSENT

By voluntarily participating in this screening program, I recognize and accept all risks associated with it. I understand that this program is only a screening program and does not constitute a complete medical exam or diagnosis. For a diagnosis of a medical problem, I must see a physician for a complete medical exam.

I, _____, have read this form and understand its content. I understand that my results will be released only to me and that the confidentiality of this data will be maintained within legal limits.

Lastly, I understand that the responsibility to initiate a follow-up examination with a physician to review the results of this screening is mine alone.

Please check the service(s) you voluntarily elect:

☐Chem Profile ☐Colorectal Disease Screening Kit ☐PSA ☐IgG Antibody Screen

If you would like the IgG COVID Antibody Screen, the following questions must be answered:

Do you work in healthcare ☐YES ☐NO

Are you symptomatic as defined by the CDC? Fever or chills, Cough, Shortness of breath or difficulty breathing, Fatigue, Muscle or body aches, Headache, New loss of taste or smell, Sore throat, Congestion or runny nose, Nausea or vomiting, Diarrhea ☐YES ☐NO If YES, date of onset of symptoms _____

Are you hospitalized ☐YES ☐ NO

Are you an ICU patient? ☐ YES ☐ NO

Do you reside in a congregate care setting? ☐ YES ☐NO

Are you pregnant? ☐YES ☐NO

_____ _____

Participant Signature Participant Name (please print)

_____ _____

Date Street Address

_____ _____

Date of Birth City, State, Zip Code