HEALTH FAIR NOVEMBER 2021

3004 Chesterfield Avenue, Charleston, WV 25304 p(304)388-5070 f(304)345-3164

Please Print:

Patient Name ____ Date of Birth ______________________

Mailing/Home Address ____________________________________ City_________________ State_______

Contact Telephone ______________________

TEST MENU

(please check requested tests)

□ CBC: Complete Blood Count
□ CMP: Comprehensive Metabolic Panel
□ Hemoglobin A1c
□ TSH: Thyroid Stimulating Hormone
*□ PSA: Prostate Specific Antigen Screen
*(Males 45 and Over)

I give my consent to Charleston Area Medical Center (CAMC) to complete blood collection and testing as noted above. I understand CAMC will provide my results to me through the method I select below. It is patient responsibility to supply results to their own physician.

I would like to receive my results by the following method: **(Please select only one)**

□ Patient Link (Internet Portal – fastest possible results)
EMAIL ____ Last 4 of SS#_____________

□ Mailed Results (Up to 5 business days after completion / must complete release of information)

Date:____/_____/2021___ Time:____________ Patient Signature:___________________________________

Signed by patient or person legally authorized to consent for patient

CAMC Staff Only	
Phlebotomist Initials:	Date &Time:
****Registration completed under (LWKCHD Kanawha Charleston Health Department)	
****Ordering Physician Dr. Sherri Young DO	