



Sheridan Memorial Hospital
 1401 West 5th Street •• Sheridan, WY 82801 •• (307) 672-1000
 Dr. William Doughty •• (307) 672-1035

www.sheridanhospital.org

WELLNESS SCREEN

Please complete this form

Location _____

Last Name _____ First Name _____

Sex (check one)

Male DOB ____/____/____ SSN ____/____/____ Physician _____
 Female (a copy will be faxed to your physician)

Mailing Address _____ City _____ State _____ Zip Code _____

Phone Number () _____ - _____ Hours fasting _____ If you have not fasted for 12 hours your results may not be accurate.
 (In case of critical test results we must be able to contact you)

GENERAL TEST REQUISTION (Please check with desired profile)		
<input type="checkbox"/> Complete Blood Count	\$15.00	CPT Code 85027
<input type="checkbox"/> Wellness Panel (includes TSH and direct LDL)	\$40.00	CPT Code(s) 82040, 83540, 83735, 84100, 84443, 84550, 86141, 82977, 83615, 82465, 83718, 84478, 83721
<input type="checkbox"/> Wellness Panel with Hemoglobin A1C	\$65.00	CPT Code(s) (above codes for Wellness and 83036) [\$40.00 + \$25.00 (HA1C)]
<input type="checkbox"/> Diabetic Management Panel May have up to 4 times per year (Glucose + HA1C)	\$35.00	CPT Code(s) 83036, 82947
<input type="checkbox"/> Cholesterol	\$ 5.00	CPT Code 82465
<input type="checkbox"/> PSA	\$28.00	CPT Code 84152
<input type="checkbox"/> Occult Blood	\$ 5.00	CPT Code 82270
TOTAL AMOUNT DUE _____		

Please initial. By initialing I am acknowledging that I understand and agree to the following statements:

_____ Two (2) copies of results will be mailed to you. Please provide a telephone number that you can be reached at in the event any of your test results fall into the critical result range.

NOTE: Please fill out your return envelope with your address.

Received by _____

Consent and Release

I hereby request and grant permission to Memorial Hospital of Sheridan County to draw blood from me for purpose of performing a set of standardized laboratory tests on that sample. I request and authorize Memorial Hospital of Sheridan County to obtain those laboratory results and forward them to me.

I understand that I am responsible for forwarding this information to my personal physician or other source of health care and that the Memorial Hospital of Sheridan County is not practicing medicine, proposing diagnoses, or recommending medical treatment, but merely acting as a resource to provide me this additional information. I understand that should I become ill, have any complications, or have any questions regarding my health, I should contact my usual source of health care. I do not hold Memorial Hospital of Sheridan County responsible in this regard. In the event of an accidental needle puncture, I consent to any routine blood testing deemed necessary for the safety of the phlebotomist.

Participant
 Signature _____ Date _____

Legal Guardian
 (If Under 18) _____ Date _____