Check ☑ the test(s) you would like:

☐ Full Cholesterol Panel w/ glucose
(Total Cholesterol, HDL, LDL, Trigs, Ratio, *Glucose)
☐ Liver Function (ALT/AST)
☐ Thyroid Screening (TSH)
☐ Prostate Specific Antigen (PSA)
☐ Hemoglobin A1c (diabetes)
☐ Blood Glucose (diabetes screening) *included in Full Cholesterol Panel

☐ **Women's Wellness Panel** ☐ **Men's Wellness Panel**

NORTHWEST HEALTH & OSTEOSCREENING™
Mobile Health Screenings
P.O. Box 44413 • Boise, ID 83711 • (208)378.4584
www.nwosteo.com

Name: _____
Last First M.I.

Address: _____
City State Zip Code

Date of Birth: ____/____/____ Age: _____ Phone: _____ Sex: ☐M ☐F

E-mail: _____ Physician or NP_____
(email will be sent to notify you of screening dates/special offers)
(your email address will NOT be given out to anyone) ☐ Please ✓ if you've been tested by us before

Heard about screening from: (circle all that apply) Newspaper / Physician / Street Sign / Store Advertisement / Friend / Employer / E-mail / Prior Patient / Other_____

Please answer the following questions:	**Yes**	**No**	**?**
1) Do you have elevated cholesterol levels or diabetes?	☐	☐	☐
2) Have any close biological relatives suffered from high cholesterol, stroke, or heart attack?	☐	☐	☐
3) Have you ever had a real or suspected heart attack, coronary occlusion or stroke?	☐	☐	
4) Do you exercise at least 3x per week?	☐	☐	
5) Do you smoke?	☐	☐	
6) Are you currently taking any cholesterol medication? Type? _____	☐	☐	

You will be screened using FDA-approved equipment for all blood tests. The tests use the finger stick method to obtain a small blood sample. Each test will take 5-10 minutes (PSA results will be sent in 2 weeks). Results will be given to you immediately after the test. There is a risk of fainting or infection associated with any skin puncture. NW Health & OsteoScreening™, Inc. personnel are not medical doctors and do not provide diagnosis or treatment. It is important to see your doctor for regular care. Insurance will not be billed; however receipts are available for possible reimbursement. This screening will not be reimbursed under Medicare.

By signing this form, and on behalf of your heirs, executors, administrators and assigns, you agree to release NW Health OsteoScreening™, Inc., and/or the institution where this screening is conducted and their respective officers, directors, employees, agents, servants and subcontractors from any liability, claim or damage for any injury suffered as a result of undergoing the aforementioned testing, for any liability, or damage suffered as a result of inaccurate or erroneous outcomes, actions, or inactions taken as a result of this test.

I have read this form and understand its contents. I understand that the results will be released to me and that the responsibility of obtaining medical treatment after receiving the results of this test is solely my own. I understand that confidentiality of this information will be maintained within legal limits. This information may be used in the future for statistical evaluation and scientific literature; however, I will not individually be identified in any recognizable way. I also allow NW Health & OsteoScreening™, Inc. to contact me at a later date regarding this or future testing.

Signature_____ **Date** _____

Please make checks payable to: NW Health & OsteoScreening

Northwest Health & OsteoScreening use only:

Healthcare Professional: _____

Rev. 2/09

Northwest Health & OsteoScreening use only:

Method of Payment: Amount:
Cash $_____
Check $_____
CC $_____