BIOMETRIC SCREENING

Information & Consent Release Form

A HEALTHIER STATE HOUSE
Healthier Leaders, Healthier South Carolina

You Must Be 18 Years of Age to Participate. Please take a moment to complete the following information. ***PLEASE PRINT.***

(Circle one)

TEAM: House Senate Staff Lobbyist Agency/State Official

NAME: _____ **AGE:** _____ **DOB:** _____/_____/_____

EMAIL: _____ **MOBILE PHONE:** _____

WORK PHONE: _____ **CITY/DIST:** _____

Please check the boxes for any coronary risk factors that apply to you:

- ☐ Man aged 45 or older?
- ☐ Woman aged 55 or older?
- ☐ Woman younger than 55 with premature menopause who is ***not*** taking hormone replacement therapy?
- ☐ Current tobacco or nicotine user (vaping/e-cigarettes)?
- ☐ A history of coronary heart disease and treatment, such as angina, prior heart attack, angioplasty, bypass surgery?
- ☐ Cerebrovascular problem such as a previous stroke?
- ☐ A diagnosis of hypertension (high blood pressure)?
- ☐ A diagnosis of diabetes (high blood sugar)?
- ☐ Known low levels of HDL cholesterol (less than 35 mg/dl)?
- ☐ A family history of early heart disease (parent or siblings, under the age of 55: male or 65: female)?

I hereby authorize and consent to the performance of a brief biometric screening, which may include written risk assessments, the taking of my blood pressure and/or obtaining a blood sample by a finger stick or venipuncture for determining my blood cholesterol and/or glucose level. These tests are not definitive for either the presence or absence of medical problems, and I understand that it is my responsibility to contact my personal physician with any questions I might have regarding the significance of the test results. The results of this screening will be released directly to me. If the results of this screening are deemed to be outside recommended values, I grant permission to be contacted for follow up. I have read the information provided on this form. I hereby release and hold harmless the South Carolina Hospital Association, its staff, employees, agents, officers, directors, and any other persons involved, from any liability, damage or claim arising from any injury or complications that may result from the performance of the screening. This form also serves as a release of my results to my personal physician.

SIGNATURE: _____ **DATE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____

Screening Results

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To be completed by a A Healthier State House representative.

YOUR RESULTS		DESIRABLE LEVEL
Total Cholesterol		Less than 200 mg/dl
HDL Cholesterol		50 mg/dl or greater
LDL Cholesterol		Less than 100 mg/dl
Triglycerides		Less than 150 mg/dl
Glucose		70-99 mg/dl if fasting less than 140 for non-fasting
Blood Pressure		<120/80 mm Hg Stage 1 Hypertension 130/80
BMI		
Waist Circumference		
Weight (lbs)		
Height (in)		

RECOMENDED FOLLOW UP

- ☐ Follow up with a physician
- ☐ Follow up with State House nurse
- ☐ Continued medication therapy
- ☐ New lifestyle management _____
- ☐ Continued lifestyle management _____
- ☐ Follow up coaching session in 3-6 months
- ☐ Other _____

A Notice of Privacy Practices is provided to all patients upon request. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information. The undersigned certifies that he/she has read the foregoing, received a copy of the Joint Notice of Privacy Practice (NPP), and is the patient, or the patient's personal representative.

PATIENT NAME: _____ **PATIENT SIGNATURE:** _____

RELATIONSHIP OF PERSONAL REPRESENTATIVE TO PATIENT _____

_____

If applicable, reason patient's written acknowledgement could not be obtained

STAFF NAME: _____ **STAFF SIGNATURE:** _____ **DATE:** _____