HealthDiagnosticLaboratoryInc.

★ Please select one

☐ Employee ☐ Spouse or Domestic Partner

PATIENT ID	★ EMPLOYEE ID	★ HISTORY
		Did you participate in the Inova Health Screening in 2014? Yes ☐ No ☐

PATIENT INFORMATION

★ Last Name: First: Middle Initial:

★ Address (Home or Mailing):

★ City: ★ State: ★ Zip Code:

★ Primary Phone: ( ) - ★ Date of Birth: / / ★ Age:

★ Secondary Phone: ( ) - ★ Sex: ☐ M ☐ F

★ Email: ★ Employer Name:

YOUR PHYSICIAN INFORMATION

★ Physician's Name: ★ Practice Name:

★ Practice Phone Number:

PATIENT CONSENT

I consent to submit my sample to Health Diagnostic Laboratory, Inc ("HDL") for testing. HDL works with physicians who will order your laboratory test(s) when medically appropriate. These physicians will not diagnose or treat you. The blood testing service from HDL (a) is provided solely for informational purposes and does not constitute treatment or diagnosis of any medical condition or the practice of medicine; and (b) is not being used as a substitute for the care, medical advice, or treatment provided by your primary care physician. You are solely responsible for forwarding your test results to your primary care physician and following up with that individual. HDL and HDL physicians shall not be liable for your failure to consult with your primary care physician or another medical professional following receipt of test results. When you participate in a blood test from HDL, you are doing so with the understanding that you/your employer is privately paying for these tests and there will be absolutely no billing to Medicare, Medicaid, or private insurance. I have read the above terms and conditions and agree to them.

★ / /

Patient Signature Date

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have reviewed HDL Notice of Privacy Practices and understand that it may be revised from time to time. I understand that any changes will be posted on HDL's website, www.hdlabinc.com, and that I am entitled to receive a copy of the notice upon request.

★ / /

Patient Signature Date

Office Use Only:

We attempted, but could not obtain written acknowledgment of receipt of our Notice of Privacy Practices, because:

- ☐ Patient refused to sign
- ☐ Emergency Situation
- ☐ Other:____________________

PHLEBOTOMIST USE ONLY

Has the Participant previously had their labs drawn by HDL? YES ☐ NO ☐ If yes, where?

Is the Participant pregnant? YES ☐ NO ☐ Does the Participant have a pacemaker? YES ☐ NO ☐

	Biometrics
Drawing Lab:	Height: feet inches
Tel. No.: ( ) - ext:	Weight: pounds
Collection Date & Time: / / : am/pm	Blood Pressure (mm/Hg): Systolic / Diastolic
Phlebotomist	Waist Circumference (inches): inches
Fasting: ☐ Yes ___ Hrs ☐ No	Body Composition (%): %

Internal Use Only: ☐ All fields with a ★ are complete.
☐ Location is checked.
☐ Phlebotomist Use Only is complete.
Initial:_______ Date:_________

***INSTRUCTIONS:**

This form **MUST** be typed, signed, printed and brought to your health assessment appointment. Handwritten copies will **NOT** be accepted.

REQUESTING LAB/INSTITUTION

V1.3

Inova WellAware Health Screening

HDL Overseeing Physician: Thomas D. Dayspring, MD

★ Please select your location of employment, or "spouse" if applicable

- ☐ Inova Fairfax Medical Campus - 0010898
- ☐ Inova Alexandria Hospital - 0010899
- ☐ Inova Fair Oaks Hosptial - 0010900
- ☐ Inova Loudon Hosptial - 0010901
- ☐ Inova Mount Vernon Hospital - 0010902
- ☐ Inova Medical Group - 0010903
- ☐ Inova Continuum of Care - 0010905
- ☐ Inova Healthplex-Urgent Care Centers - 0010906
- ☐ Inova System Office - 0010904
- ☐ Inova Spouse-Domestic Partner - 0010907

CUSTOM PANELS

☐ **Custom Employer Panel**

Lipid Panel
hsCRP
Insulin
Glucose
HbA1c
TSH
ALT
Creatinine
Cystatin C
LDL-P & HDL-P

Joseph P. McConnell, Laboratory Director
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Richmond, VA 23219
CLIA No. 49D1100708 | CAP No. 7224971 | NPI No. 1629209853