ORLANDO HEALTH®

**Outpatient Laboratory**

| LAB USE ONLY | |
|---|---|
| MR# | |
| Account# | |
| Accession# | |

**LABORATORY REQUISITION FORM**

Client# 3534 Healthchoice,OE
Ordering MD: Dr. P.K Michaels

**Instructions: Please complete prior to appointment**

1. **Complete the information below and sign the consent.**
2. **Bring this completed form, Healthchoice Card and Photo ID to your appointment.**
3. **Results will be provided via the Patient Portal, your email address is required.**

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**PLEASE PRINT CLEARLY**

FIRST NAME (LEGAL): _____ LAST NAME (LEGAL): _____

TEAM MEMBER #: _____ DATE OF BIRTH: _____

SEX: M [ ] F [ ] Last(4)digits of Social Security#: _____

HOME MAILING ADDRESS:

_____

_____
(CITY) (STATE) (ZIP)

HOME PHONE: _____ WORK PHONE: _____

EMAIL ADDRESS(**Required**): _____

## CONSENT AND RELEASE FORM FOR BLOOD TESTS

I hereby consent to participate in the wellness screening and give permission to OH staff to draw a blood specimen for the purpose of wellness testing.
I understand that:
1. The data derived from this testing is considered preliminary and does not constitute a diagnosis.
2. The responsibility for initiating a follow-up examination to confirm the results of this blood test and obtain professional medical assistance is the participant's alone and not that of any person(s) or organization associated with this blood test.
3. Test results will be released to the patient and to the ordering physician.
4. Tests will only be performed on those that are accompanied by a signed Consent and Release form.

**YOUR SIGNATURE:** _____
(MUST BE 18 YEARS OF AGE OR OLDER)

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**LAB USE ONLY:** _____ **Fasting [ ] Non-fasting [ ]**
**Date/Time of Collection/ User ID**
**Test: [ ] Healthchoice Biometric Panel (Lavendar and Green vacutainer)**

**Height:** _____ **Weight:** _____ **Blood Pressure:** _____
**(Inches)** **(lbs.)** **(Systolic/Diastolic)**