Health Directions

3239 Sunset Boulevard
West Columbia, SC 29169
(803) 791-2113

Lexington Medical Center

☐ **Labs Only** ☐ **Complete Screening**

PATH Test Ordered:
Lipid Profile / Iron / CBC / CMET / TSH / PSA
Send Results To: Health Directions

PATH Registration Screening Consent and Release Form

☐ **EMPLOYEE** ☐ **SPOUSE** ☐ **VOLUNTEER** ☐ **CHAPLAIN**

First Name:_____ **Last:**_____ **Middle Init:**_____

Formerly Used Names (First and/or Last):_____

Social Security Number:_____ **Date of Birth:**_____ **Age:**_____

Sex: ☐ Male ☐ Female **Race:**_____

Employee Badge #_____ **Department** Number:_____ Name:_____

Home Address:_____

City:_____ **State:**_____ **ZIP:**_____

Telephone: (Work) _____ (Home/Cell):_____

Are you currently pregnant? ☐ YES ☐ NO

Do you currently take medications for any of the following conditions (check all that apply)? ☐ Diabetes ☐ Blood Pressure ☐ Cholesterol

---

I, the undersigned applicant, for and in consideration of the benefit to be derived by participation in Lexington Medical Center's screening, do hereby release and forever discharge Lexington Medical Center, its agents, servants, representatives, and staff from and against any and all liability and responsibility for any injury, illness or sickness which may result from participation in this screening, and do hereby further agree to indemnify and hold harmless Lexington Medical Center, its agents, servants, and employees, from all liability in such regard. In the event of an employee needle stick, I consent to appropriate tests for the presence of infections, such as, but not limited to, infections by the Hepatitis B Virus or the Human Immunodeficiency Virus, if deemed necessary for the protection of others, and authorize testing for this purpose.

I understand and agree that this is a voluntary wellness program and that I will not be penalized in any way if I elect not to participate. I understand that I may be requested or required to disclose genetic information, including family medical history, as part of this voluntary wellness program. I understand that genetic information includes information about my genetic tests, the genetic tests of a member or members of my family, and the manifestation of a disease or disorder in a member or members of my family. I understand that only myself and the licensed health care professionals involved in providing this screening will receive individually identifiable information concerning the results of this screening. I understand that any individually identifiable genetic information provided in connection with this screening is only available and to be used for purposes of this program and will not be disclosed to my employer (or, where applicable, my spouse's employer) except in aggregate terms that do not disclose my identity or the identity of a member or members of my family.

I hereby knowingly and voluntarily authorize the disclosure and use of genetic information in connection with this voluntary wellness program. I, the undersigned participant consent to receiving my PATH results by mail using a confidential sealed envelope. All information from this program is confidential and will be viewed only by Health Directions staff and myself.

_____ _____
Applicant's Signature Date

For Office Use Only

Height (inches):_____ **Weight** (pounds):_____

Blood Pressure: Systolic:_____ Diastolic:_____

Smoking Status: Use of tobacco products in the last 90 days?
☐ YES ☐ NO

Exercise Frequency:_____ per week

Exercise Location:
☐ **HD Wellness Center** ☐ **HD Irmo**
☐ **Other gym** ☐ **Home**

Body Fat%:_____ **Body Mass Index:**_____

Waist Girth:_____ **Hip Girth:**_____

Glucose:_____

Total Cholesterol:_____

Triglycerides:_____

HDL:_____ **LDL:**_____

TC/HDL Ratio:_____