Jay County Hospital
Health Dept OutReach

As a community service, **Jay County Hospital** offers health department screening. Payment is required at time of service; credit card, check or exact cash amount is accepted. To take advantage of this offer, please bring this completed form to Jay County Hospital LAB.

Offer expires 12/31/17

Lab draw hours: Monday-Friday 7am-6pm and Saturday 7am-Noon

We suggest that you share your questions and results with your doctor. Positives will be reported to State and local agencies as appropriate.

Results will be mailed within 7-10 days.

☐	**GC/CT Neisseria gonorrhoeae/Chlamydia trachomatis** (urine) **183194**	**$ 25.00**
☐	**HBSAG Hepatitis B Surface Antigen 006510**	**$ 25.00**
☐	**HCVAB Hepatitis C Virus Antibody 140659**	**$ 25.00**
☐	**HIV SCREEN 083935**	**$ 25.00**
☐	**RPR/Syphilis Screen**	**$ 25.00**
	Total $	

★ **Patient Information**: Please provide **ALL** information

Name (print)	Last	First		MI	
Address	Street			APT#	
	City	State	ZIP		
Date of Birth		Sex		Phone	
SS#		(optional) Copy To:			

- ☆ I am requesting and granting permission for Jay County Hospital to perform laboratory screening tests which may include obtaining a blood sample by venipuncture. These results will be mailed to me at the address above. However, I understand that JCH may forward these test results if my physician's office calls to request a copy. I understand that JCH will assume that he/she is doing so with my knowledge and that this is for my present and/or future treatment or care.
- ☆ I understand that Jay County Hospital is not proposing a diagnosis, treatment, or offering medical advice by supplying the screening tests.
- ☆ I understand that should I become ill, have any complaints, or have any questions regarding my health; it is my responsibility to contact my physician. I understand that it is my responsibility to contact my physician regarding my results, including critical results.
- ☆ I understand that Jay County Hospital disclaims any liability for any costs, claims, injuries, actions or damages suffered by an individual, no matter what their relationship, as a result of participation in the OutReach Program. These tests will not be billed to my insurance, Medicare, or other third party payors. My participation in this program is strictly voluntary.
- ☆ I agree to release Jay County hospital and any other person associated with the OutReach Program from any liability whatsoever in connection with sample collection, testing, reporting or any other aspect of this screening.

_____ Patient Signature

_____ Date

To be completed by JCH phlebotomist:

DATE DRAWN	TIME	Phlebotomist ID