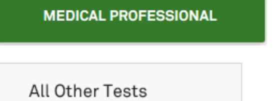
Instructions for Quest Patient Service Center (PSC)

PARTICIPANT INSTRUCTIONS:

1. **Complete the Quest Requisition Form included in this packet.** Bring the completed form and these instructions with you to the PSC. You are only eligible to receive the company paid base test listed on the requisition form (no optional tests).
2. **Choose a Quest Patient Service Center (PSC) location**. An appointment is not required but appointments take priority over walk-ins. **If you would like to make an appointment, you can do so at www.questdiagnostics.com/appointment.** This link will also provide the most up-to-date PSC locations near you; simply enter your zip code.
   a. **Take note of the hours that your chosen site is open.** Many close for lunch.
   b. When site asks, "**Who is sending you for testing?**" click on

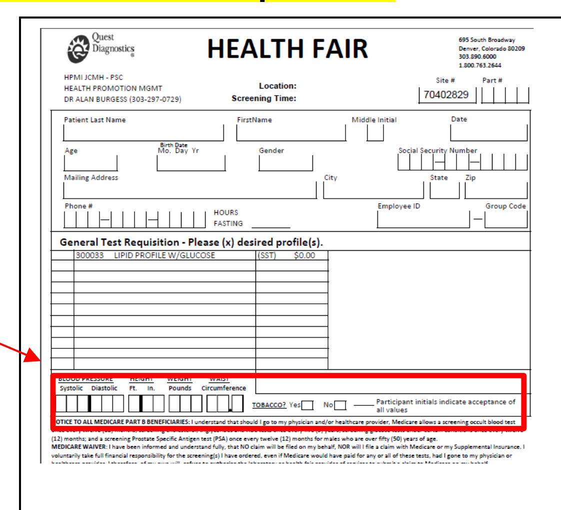
   

   c. When site asks, **"What testing do you need?"** click on All Other Tests
   d. **Take this form with you and give to the phlebotomist**
3. **Instructions for a good draw.** ** FAST for 10-12 hours prior to your appointment but stay well hydrated. People with diabetes should NOT fast. Take all necessary medications. ** Drink a glass of water one hour before your appointment time.
4. **Your blood results will be mailed to the address you put on the Quest Requisition Form. Print legibly.** You should receive the results within 2-3 weeks of going to the PSC.
5. **The deadline for the PSC option is 2/14/2019. Therefore, you must visit a PSC location by this date.**
6. **Contact HPMI if you have any questions –** 720-214-3188. If you are at the PSC and they have questions, please refer them to the Quest Health Fair Department number at the bottom of this page.

****QUEST PSC STAFF INSTRUCTIONS:

Do not enter into Care 360. Send directly to Denver Health Fair Department.

1. **Do not collect money from the participant**
2. Add draw fee (test # 3259) to requisition form
3. Take biometrics and write results on requisition form as indicated
   - Systolic and Diastolic Blood Pressure. RE-TAKE if either value is ≥140 OR ≥90) and record the lower value
   - Height (feet and inches)
   - Weight
   - Waist circumference (to the nearest ½")
   - Tobacco – Check either **Yes** or **No** after asking the participant if they are tobacco free. (This question may or may not be on the form.)
4. Have participant initial acceptance of values
5. Draw appropriate tubes
6. Label tubes with **name, date of birth and date of draw**
7. Spin SSTs
8. Send to main lab in specimen bag and mark on the outside **'HEALTH FAIR'**



Quest Diagnostics

HEALTH FAIR

695 South Broadway
Denver, Colorado 80209
303.890.6000
1.800.763.2644

HPMI JCMH - PSC
HEALTH PROMOTION MGMT
DR ALAN BURGESS (303-297-0729)

Location:
Screening Time:

Site # 70402829 Part #

Patient Last Name | FirstName | Middle Initial | Date

Age | Birth Date Mo. Day Yr | Gender | Social Security Number

Mailing Address | City | State | Zip

Phone # | HOURS FASTING | Employee ID | Group Code

General Test Requisition - Please (x) desired profile(s).

	300033 LIPID PROFILE W/GLUCOSE	(SST)	$0.00

BLOOD PRESSURE Systolic Diastolic | HEIGHT Ft. In. | WEIGHT Pounds | WAIST Circumference

TOBACCO? Yes ☐ No ☐ ____ Participant initials indicate acceptance of all values

NOTICE TO ALL MEDICARE PART B BENEFICIARIES: I understand that should I go to my physician and/or healthcare provider, Medicare allows a screening occult blood test ... (12) months; and a screening Prostate Specific Antigen test (PSA) once every twelve (12) months for males who are over fifty (50) years of age.

MEDICARE WAIVER: I have been informed and understand fully, that NO claim will be filed on my behalf, NOR will I file a claim with Medicare or my Supplemental Insurance. I voluntarily take full financial responsibility for the screening(s) I have ordered, even if Medicare would have paid for any or all of these tests, had I gone to my physician or

For Questions please call the Health Fair Department:
303-899-6703 (Geri) or 303.899.6591 (Melissa)

HEALTH FAIR

695 South Broadway
Denver, Colorado 80209
303.890.6000
1.800.763.2644

HPMI UCAR/NCAR-PSC
HEALTH PROMOTION MGMT
DR ALAN BURGESS
303-297-0729

Site # 70372074
Part #

Patient Last Name | FirstName | Middle Initial | Date

Age | Birth Date Mo. Day Yr | Gender | Social Security Number

Mailing Address | City | State | Zip

Phone # | HOURS FASTING ________ | Employee ID N/A — Group Code 99

General Test Requisition - Please (x) desired profile(s).

x	322940 FULL CHEM SCREEN W/TSH	(SST)	$00.00	
	5363 PSA (MEN ONLY)	(SST)	$00.00	

Total $: ________ ____________________________ Received By

NOTICE TO ALL MEDICARE PART B BENEFICIARIES: I understand that should I go to my physician and/or healthcare provider, Medicare allows a screening occult blood test once every twelve (12) months; screening cholesterol, triglycerides and HDL tests once every five (5) years; screening glucose tests under certain conditions once every twelve (12) months; and a screening Prostate Specific Antigen test (PSA) once every twelve (12) months for males who are over fifty (50) years of age.

MEDICARE WAIVER: I have been informed and understand fully, that NO claim will be filed on my behalf, NOR will I file a claim with Medicare or my Supplemental Insurance. I voluntarily take full financial responsibility for the screening(s) I have ordered, even if Medicare would have paid for any or all of these tests, had I gone to my physician or healthcare provider. I therefore, of my own will, **refuse to authorize** the laboratory or health fair provider of services to submit a claim to Medicare on my behalf.

MEDICARE
Participant Signature: ________________________________

Consent and Release

I hereby request and grant permission to the Health Fair Organization, the local Health Fair Coordinators and Volunteers, and Quest Diagnostics Incorporated to draw blood from me for the purpose of performing a set of standardized laboratory tests on that sample. I request and authorize the Health Fair Organizations to obtain those laboratory results and forward them to me.

I understand that I am responsible for forwarding this information to my personal physician or other source of health care and that the local HealthFair Coordinators and Volunteers, Quest Diagnostics and Health Fair Organizations are not practicing medicine, proposing diagnoses, or recommending medical treatment, but merely acting as a resource to provide me this additional information. I understand that should I become ill, have any complications or have any questions regarding my health, I should contact my usual source of health care. I do not hold the local Health Fair Coordinators and Volunteers, Quest Diagnostics, the above named ordering physician, or Health Fair Organizations responsible in this regard. In the event of an accidental needle puncture, I consent to any routine blood testing deemed necessary for the safety of the phlebotomist.

Participant
Signature ________________________________ Date ________________

Legal Guardian
(If Under 18) ________________________________