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 test(s) 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](http://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
   - d. Take this form with you and give to the phlebotomist

3. **Instructions for a good draw.**
   - Stay well hydrated - *drink 1-2 glasses of water one hour before your appointment time*
   - Fast for 12 hours prior to your appointment but stay hydrated (water only). NOTE: People with diabetes should NOT fast.
   - Take all necessary medications.
   - Avoid strenuous exercise 12 hours prior to the screening.
   - Refrain from drinking alcoholic beverages for at least 12 hours prior to your appointment.
   - Limit caffeine and nicotine one hour prior to your appointment.

4. **Your blood results will be mailed to the address you put on the Quest Requisition Form.** Print legibly. You should receive the results approximately 3 weeks after going to the PSC.

5. **The deadline for the PSC option is 2/13/2020.** 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:

---

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 \( \geq 140 \) OR \( \geq 90 \) and record the lower value
   - Height (feet and inches)
   - Weight
   - Waist circumference (to the nearest \( \frac{1}{2} \)“)
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’

---

For Questions please call the Health Fair Department:
303-899-6703 (Geri) or 303.899.6591 (Melissa)
General Test Requisition - Please (x) desired profile(s).

<table>
<thead>
<tr>
<th>Test Code</th>
<th>Description</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>322940</td>
<td>FULL CHEM SCREEN W/TSH (SST)</td>
<td>$0.00</td>
</tr>
<tr>
<td>5363</td>
<td>PSA (PROSTATE SPECIFIC ANTIGEN) (SST)</td>
<td>$0.00</td>
</tr>
</tbody>
</table>

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: ________________________________

INFORMATION RELEASE AND NOTIFICATION

I am aware that the information gathered through the health screenings is considered to be private health information (PHI). I release my PHI to Health Promotion Management, Inc., and other affiliates, subsidiaries and trusted partners who work on behalf of or with Health Promotion Management, Inc. or my employer under confidentiality agreements to assist my employer in its health care operations, and my physician, if requested by me. Information gathered will be used for aggregate reporting to the company. It will not be possible to identify any individual person in this reporting. Other uses or disclosures of my PHI will be made only with my written permission. I take full responsibility for initiating follow up examination(s) by my physician that may be needed to confirm the results of the screenings. If I am at high risk in any of the health areas, I may be contacted by a Health Promotion Management, Inc. staff member or a health educator designated by Health Promotion Management, Inc. Information concerning current blood work testing, blood pressure, body weight, and other screenings will be entered on this Health Screening form by the screeners designated by Health Promotion Management, Inc. Interpretation of my results is also considered confidential. I agree that participation in the screening process and interpretation consultation is totally voluntary.

CONSENT & LIABILITY STATEMENT

In consideration of the blood sampling and other screenings to be performed and the potentially beneficial health information gathered therefrom, I request and give my expressed consent that such blood sampling and screenings be performed and that the results be forwarded to me, and hereby release Health Promotion Management, Inc., the facility in which the test is being performed, the above named ordering physician, all associated personnel, and all employees and agents thereof from all liability (other than liability for negligence) that may result from the screenings and drawing of blood and subsequent blood analysis. I understand the blood chemistry analysis and other screenings are for informational purposes only, and the phlebotomist who is drawing the blood sample, personnel conducting the other screenings, the facility in which the test is being performed, and Health Promotion Management, Inc. are NOT expected to render a medical opinion or give medical advice. I further understand that only a medical physician is qualified to render medical advice and/or diagnosis of illness. In the event of an accidental needle puncture, I consent to any routine blood testing deemed necessary for the safety of the phlebotomist.

I have read the above statements and understand their content.

Participant Signature: ________________________________ Date: __________________________

Total $: _______ Received By __________________________

______ Participant initials indicate acceptance of all values

BLOOD PRESSURE
Systolic     Diastolic     Ft.    In.    Pounds   Circumference

[ ]  [ ]  [ ]  [ ]  [ ]  [ ]

HEIGHT

WEIGHT

WAIST

Participant Signature: ________________________________ Date: __________________________

322940 (SST) $0.00
5363 (SST) $0.00

Participant Signature: ________________________________ Date: __________________________