

LOGAN COUNTY DEPARTMENT OF PUBLIC HEALTH

(217) 735-2317

\$10.00 FEE

Hemoglobin Screening Referral and Follow-up Form

Personal Information (Please Print)

Name _____ M _____ F _____ Age _____

Address _____ Phone# _____

Medical Information:

1. Have you ever been told you have low hemoglobin?
Yes _____ No _____ Unknown _____

2. Are you anemic or do you have a health condition that may affect your hemoglobin?
Yes _____ No _____ Unknown _____

3. Are you currently taking any medication for anemia/low-iron in your blood?
Yes _____ No _____ Unknown _____

Physician: _____ Phone#: _____

Address: _____

Hemoglobin Results: _____ gm/dl

Normals: Males 14-18 gm/dl _____referred
Females 12-16 gm/dl _____referred

A single measurement is not conclusive, so if your value is low, you should see your doctor as soon as convenient (but within the next 4 weeks). He/she will retest your hemoglobin, evaluate your condition, and tell you what steps you should take to bring your level to a normal value.

Consent and Release Statement:

I hereby release the Logan County Department of Public Health, other organizations associated with this screening, parent and affiliated companies, successors, and assigns, officers, directors, and employees from any and all liability arising from or in any way connected to blood drawing for my hemoglobin measurement or from the data derived there from. I understand that:

1. The data derived from this test are to be considered as preliminary only and are in no way conclusive.

2. If my test results suggest that I may be at increased risk, I request that the screening sponsors send my results to my physician: Yes _____ No _____ Don't have a physician _____

3. Logan County Department of Public Health will also receive a copy of this completed form, including test results, for research purposes only.

4. The responsibility for initiating a follow-up examination to confirm low hemoglobin and obtain advice and treatment is mine and not that of my physician or the organizations associated with this screening.

I also hereby acknowledge that I received a copy of the "Notice of Privacy Practices" from the Logan County Dept. of Public Health revised 9/23/2013.

Signature _____ Date _____