

**Livingston Health Dept. Blood Work Registration Form**  
**September 20, 2003 8:30am – 11:30 am**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ MI: \_\_\_\_\_

Address \_\_\_\_\_ Sex: M / F \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Daytime Phone #(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

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Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

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Health Profile (\$15) \*(includes CBC, Chemistry & Lipid Panel

*\*Please note that this test requires a 12 hour*

*fast. Check with your physician for medications.*

Lyme Disease (\$30)

PSA(\$30)

Blood Type & RH Factor (\$10)

Thyroid T3 (\$5)

Thyroid T4 (\$5)

Thyroid TSH (\$10)

Hepatitis C Screening (\$25)

Hepatitis B Surface Antibody (\$25)

***Those wishing to participate must complete form and return it with two stamped legal size envelopes ( one self-addressed and one addressed to your physician). Make check payable to: Medical Laboratory Diagnostics***

**Please read and sign disclaimer below:**

I understand that these tests should not be in place of a routine physical exam and should be reviewed by my physician. I release the sponsoring organization from any responsibility or liability from health consequences, that may occur from my participation in this event.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

-----For Office Use Only-----

Total Amount Due: \$ \_\_\_\_\_ Paid on Date: \_\_\_/\_\_\_/\_\_\_

Paid by Cash \_\_\_\_\_ Check # \_\_\_\_\_