CONSENT FOR MEDICAL TESTS AND SERVICES

By way of my signature below, I consent to and allow the FARMacy Team to perform a rapid HbA1c test and rapid lipid profile as well as recording body weight, waist circumference, and blood pressure as baseline data for this program. I understand that the purpose of these tests are for evaluating the effectiveness of this program but if there are abnormalities, we can provide assistance in connecting you with your provider who ordered the tests. As with any clinical test, there is the potential for side effects. Descriptions and side effects for each test are listed below. If at anytime you would like to opt out of any of these tests, just let us know. These tests are 100% voluntary and do not disqualify you from participating in the FARMacy program.

Rapid HbA1c test: finger prick test, which could cause momentary discomfort, puncture site soreness, or bruising

Rapid lipid profile test: finger prick test, which could cause momentary discomfort, puncture site soreness, or bruising

Body weight: measured by stepping on a scale

Waist circumference: measured by a clinic volunteer using a tape measurer

Blood pressure: measured with a blood pressure cuff*

*Alert the clinic volunteer if you have any of the following conditions: a deep, serious, or non-healing wound, an arteriovenous (AV) graft or fistula, which is used for dialysis, IV line, peripherally inserted central catheter (PICC line), or any other medical device, or lymphedema, which is a blockage of the lymphatic system that causes swelling of an arm or leg, side effects could include momentary discomfort, bruising

If you have any questions or concerns about these tests, or your test results, contact Dr. Carol Greco at c_greco_do@msn.com.

Would you like to share your test results with your provider? If so, please initial below (and list your provider's name).

Initial ___________ Date _________

Provider name____________________ Provider clinic__________________

By way of my signature below, I release the FARMacy team from liability related to the previously mentioned side effects related to these tests.

Name (please print) ____

Signature _____________________________ Time ___________Date _________

Signature
of Witness ____________________________ Time ___________Date _________