CityLife Health

Community Care Consent for Treatment

CityLife Neighborhood Clinics offers preventive care & screenings to members of our community. In order to receive such preventive care, please complete this form in its entirety.

Patient Name: _____ **Date of Birth:** _____

Name of Parent or Legal Guardian (if patient is 18 or younger): _____

Relationship to Patient (circle one): Mother / Father / Legal Guardian

I give my permission for CityLife Neighborhood Clinics to perform the following screening tests (check all that apply):

- ❑ Point of care lead level testing via finger stick
- ❑ For lead levels over 5, confirmation testing via venous blood draw
- ❑ Point of care hematocrit and/or hemoglobin test (for checking for anemia or nutritional status)
- ❑ Body Mass Index (measurement of height and weight)
- ❑ Vision Screening
- ❑ Hearing Screening
- ❑ Physical Exams for school, daycare, or sports physical
- ❑ Vaccinations (see separate vaccine consent forms)

I understand that there are possible risks from taking a blood sample by finger stick, including: excessive bleeding; scarring (occurs when there have been multiple punctures in the same area); rarely, an infection; and, uncommonly, faintness from the procedure. Damage to blood cells from this method of collection can sometimes cause inaccurate test results and the need to repeat the test with blood drawn from a vein. If a venous blood draw is needed, additional risks may include discomfort at the site of puncture and possible bruising and swelling around the puncture site.

I understand that any test results must be reviewed by my personal physician for proper interpretation and medical diagnosis. If my physician is not at CityLife Neighborhood Clinics, then I understand it is my responsibility to provide the test results to my personal physician and seek any follow-up care from my physician.

I hereby release, discharge, and agree to hold harmless CityLife Neighborhood Clinics, CityLife-PA, P.C., Ampersand Health-PA, LLC, and their affiliates, employees, agents, officers, directors and representatives from any and all damages, losses, injuries or liability whatsoever which may arise from my participation in the preventive care and screenings listed above.

By signing below, I acknowledge that I have read and understand this Consent for Treatment.

Signature of Patient/Legal Guardian: _____

Date: _____

Please provide the following contact information in order to receive test results:

Home Address (include city, state and zip code): _____

Telephone Number (include area code): _____

Please provide the following insurance information required for sending any venous samples to laboratory (if not insured, leave blank):
Insurance Provider Name: _____
Policy ID#**:** _____