



CAMP VALLEY VISTA WELLNESS FAIR

(PLEASE PRINT) ALL INFORMATION REQUIRED IN ORDER TO COMPLETE TESTING

NAME _____
LAST FIRST M.I.

BIRTHDATE _____ **PHONE** _____

ADDRESS _____

I HAVE READ THE FOLLOWING INFORMATION AND UNDERSTAND:

- ❖ Results will be mailed to your home address.
- ❖ Results will not be sent to a physician. No insurances will be billed.
- ❖ If abnormal results are obtained, you will be contacted to seek medical attention.

SIGNATURE _____

PLEASE MARK AN "X" NEXT TO THE TESTING YOU WISH TO HAVE DONE.

____ **EXECUTIVE Profile (CBC, COMPREHENSIVE PANEL, LIPID PANEL) \$20.00**

____ **TSH (THYROID HORMONE) \$10.00**

____ **PSA (PROSTATE) \$10.00**

____ **Testosterone \$20**

____ **Vitamin D, 25-Hydroxy \$30.00**

____ **Vitamin B12 and Folate \$20.00**

____ **HGB A1C (DIABETIC 3 MONTH SCREEN) \$15.00**

____ **C REACTIVE PROTEIN CARDIAC (CRP by high sensitivity may add to the predictive value of other markers used to assess the risk of cardiovascular and peripheral vascular disease) \$10.00**

____ **C REACTIVE PROTEIN INFLAMMATORY (Inflammatory conditions including: bacterial infection, rheumatic fever, active arthritis, myocardial infarction, and malignancies) \$10.00**