

about your
WELLNESS LABS

Burgess Health Center has prepared this brochure as a guide to explain your wellness lab choices and results.

The information in this brochure and your results should not be used for a diagnosis.

Blood tests are compared to a “reference range” based on healthy people. Even healthy people may have a test result slightly outside of the reference range. Discuss this result with your healthcare provider.

Please contact your healthcare provider with any questions you may have regarding your results.

Thank you for choosing Burgess for your wellness lab needs.

BEFORE APPOINTMENT

Some of these labs require you to fast – meaning no eating or drinking – for 12 hours prior to your test. If you do not fast, your results might not be accurate. Please call your primary healthcare provider to see if you should take your medications or wait to take them after your lab appointment.

AFTER APPOINTMENT

Your results will be mailed to your home. If you gave us your healthcare provider’s name, we will fax your results to his or her office. You are responsible for sharing any result concerns with your provider.



WELLNESS LAB COST

Chem Profile	\$35
Cholesterol Panel.....	\$10
A1C.....	\$15
CBC.....	\$10
PSA.....	\$15
TSH	\$15
Vitamin D	\$55

Wellness lab tests are not billable to insurance, Medicare or Medicaid.

make your
APPOINTMENT

Please call Centralized Scheduling for a wellness lab appointment time.
Phone: (712) 423-9363

Wellness lab appointments are held:
Wednesdays, 6:30 - 8:00 a.m.

On the day of your appointment, please come to Burgess Health Center in Onawa, Iowa. You will not need to check in at the front desk and can wait in the outpatient clinic waiting area. A member of the lab staff will greet you there. If you are not sure where to go, stop by the front registration desk for directions to the waiting area.

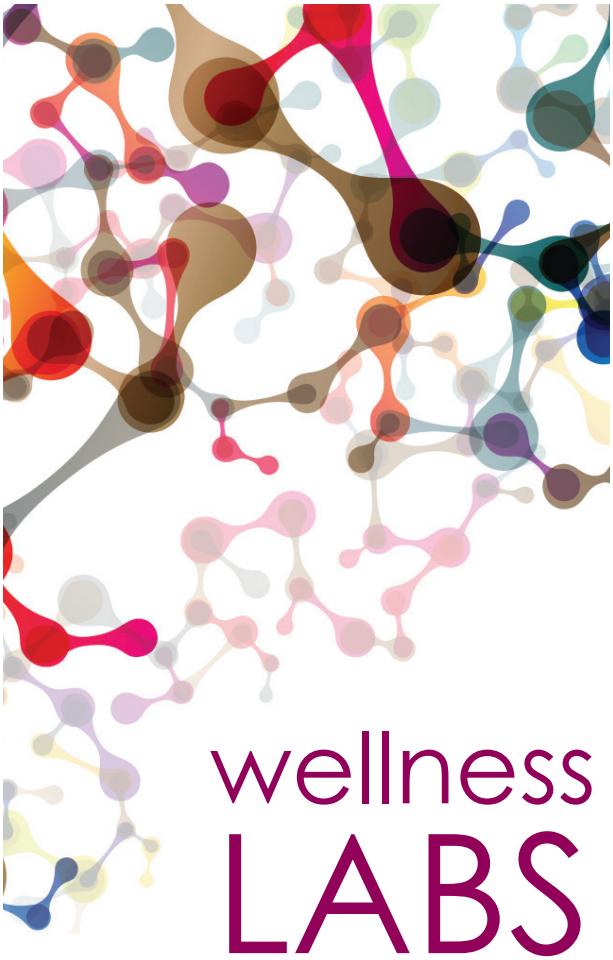
Payment will be due at the time of service. If paying with credit or debit card, please stop at the front desk.

Your appointment is scheduled for:

Date: _____

Time: _____

Special Instructions: _____



BURGESS
Health Center
QUALITY CARE YOU CAN BELIEVE IN

Burgess Laboratory

1600 Diamond Street
Onawa, Iowa 51040
www.BurgessHC.org

select your WELLNESS LABS

Please place a check next to the tests you would like to have completed.
You may want to have your healthcare provider fill out this section.
Reminder - some of these lab tests require you to fast.

- ☐ **CHEM PROFILE** **\$35**
Helps evaluate the status of several major organs, including kidneys and liver. Includes the cholesterol panel listed below.
Must fast for 12 hours prior to this test.
- ☐ **CHOLESTEROL PANEL** **\$10**
This profile includes HDL, LDL, glucose, cholesterol and triglycerides.
Must fast for 12 hours prior to this test.
- ☐ **A1C** **\$15**
Elevated levels may be suggestive of diabetes.
- ☐ **CBC.....** **\$10**
Determines the white and red blood cell counts, hemoglobin, hematocrit, and platelet count in blood. Can detect anemia and some infections.
- ☐ **PSA** **\$15**
Can detect prostate cancer and other benign prostate disorders.
- ☐ **TSH.....** **\$15**
Abnormal values may be associated with an underactive or overactive thyroid.
- ☐ **VITAMIN D** **\$55**
Measures the amount of vitamin D in the blood. Your body needs vitamin D to absorb calcium.

WELLNESS LAB REGISTRATION

Please print the following information.

Name _____

Date of Birth _____

☐ Male

☐ Female

Address _____

City _____ State _____ Zip _____

Telephone # _____

Healthcare Provider Name _____

Provider Clinic Location _____

☐ No current healthcare provider

COMPLETE AT CHECK-IN

Have you eaten anything in the last 12 hours?

☐ Yes

☐ No

Did you drink anything other than water in the last 12 hours?

☐ Yes

☐ No

AUTHORIZATION

I understand these results do not constitute a diagnosis, and **I am responsible for initiating a follow-up with my healthcare provider.** _____ *Initial*

I understand that these results will be in my healthcare record at Burgess Health Center. _____ *Initial*

I authorize the release of my test results to myself and the healthcare provider listed above. ☐ Yes ☐ No

Signature _____ Date _____

Payment Amount _____ How Paid _____

Time Drawn (staff to complete) _____