



### Acknowledgement of Risks and Side Effects and Informed Consent Waiver

#### I acknowledge and I understand:

- The potential risks and/or side effects have been explained to me.
- I voluntarily assume all risks related to my participation.
- I will have my finger pricked in order to provide a blood sample to a registered health professional for blood glucose and blood cholesterol measurements.
- Most people experience slight discomfort with this procedure.
- The incidence of infection with this procedure is very low and might be influenced by variables such as immune deficiency.
- I may ask any questions or request further explanation or information about the procedures at any time before, during or after the screening.
- I have had the opportunity to ask questions which were answered to my satisfaction.
- I may stop or delay any further testing if I so desire.
- Screening may be terminated by the registered health professional upon observation of any symptoms of undue distress or abnormal response.
- I waive and release any and all claims, causes of action, liability or damages that I, or anyone claiming on my behalf, may have against The Health Team and each of their directors, officers, employees and agents arising from or related in any way to my participation in this screening initiative, including but not limited to, on account of any injury or damages I may suffer as a result of this finger prick or the results.
- The purpose of the screening program is to heighten my awareness and education of the screening topic.
- All measurements obtained are for screening purposes only and are not diagnostic in nature.
- These figures do not constitute, and should not be substituted for, professional medical advice.
- I am urged to consult with my physician for diagnosis and treatment of any health related condition.
- Any personal contact or results information I provide will form part of a confidential database. By completing this form, you have agreed to release this information, and for it to be made available to The Health Team. Under no circumstances will identifiable individual data be made available to your employer or any other third party.

#### I give my consent to have a registered health professional perform and provide results for the following health related measurements:

- Blood pressure
- Total blood cholesterol
- Blood glucose
- Height
- Weight
- Body mass index
- Waist circumference

**I, the undersigned, have read, understood and agree to the terms and conditions set out above. My signature confirms my consent to the parameters around the collection, use and disclosure of my personal health information by The Health Team.**

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

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

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

# Health Screening

## Results Tracking Form

### Preliminary Questions

Gender: Male Female    Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Smoking Status: Yes No (0 cigarettes in past 30 days)    Are you pregnant? Yes No N/A

Measurement	Result	Category	
Blood Pressure	Systolic _____ mmHg Diastolic _____ mmHg	<input type="checkbox"/> Low Risk (systolic below 120 AND diastolic below 80) <input type="checkbox"/> Moderate Risk (systolic 120-139 OR diastolic 80-89) <input type="checkbox"/> High Risk (systolic 140 and above OR diastolic 90 and above)	
Total Blood Cholesterol	_____ mmol/L	<input type="checkbox"/> Optimal (below 5.2) <input type="checkbox"/> High (5.2 and above )	
Glucose	_____ mmol/L	<b>Fasting (8 hrs. or more)</b> <input type="checkbox"/> Optimal (below 7.0) <input type="checkbox"/> High (7.0 and above)	<b>Casual</b> <input type="checkbox"/> Optimal (below 11.0) <input type="checkbox"/> High (11.0 and above) <input type="checkbox"/> Symptoms of diabetes
		<b>Symptoms of diabetes:</b> <ul style="list-style-type: none"> <li>•Unusual thirst</li> <li>•Frequent urination</li> <li>•Weight change</li> <li>•Extreme fatigue or lack of energy</li> <li>•Cuts and bruises that are slow to heal</li> <li>•Tingling or numbness in the hands or feet</li> <li>•Trouble getting or maintaining an erection</li> </ul>	
Height	_____ Feet _____ Inches	N/A	
Weight	_____ Pounds	N/A	
Body Mass Index	_____ kg/m <sup>2</sup>	<input type="checkbox"/> Underweight (less than 18.5) <input type="checkbox"/> Optimal (18.5-24.9) <input type="checkbox"/> Overweight (25-29.9) <input type="checkbox"/> Obese (30 and above)	
Waist Circumference	_____ Inches	<b>European, Caucasian, Sub-Saharan Africans, Eastern Mediterranean, Middle Eastern</b> <input type="checkbox"/> Optimal (male: 40 and below; female: 35 and below) <input type="checkbox"/> High (male: above 40; female: above 35)	<b>South Asian, Malaysian, Asian, Chinese, Japanese, Ethnic South and Central Americans</b> <input type="checkbox"/> Optimal (male: 35 and below; female: 32 and below) <input type="checkbox"/> High (male: above 35; female: above 32)

### Additional Notes