



Screening Consent Form

Operation Diabetes
Wisconsin Society of Pharmacy Students
UW-Madison School of Pharmacy



American Pharmacists Association
Academy of Student Pharmacists



Date: _____

Name: _____ DOB: ___ / ___ / ___ Age: _____ Male / Female
First Last

Address: _____
Street City State Zip

Phone: () _____ --- _____ Other: _____

Doctor's Name: _____ Address: _____

Doctor's Phone: () _____ --- _____ Fax: () _____ --- _____

I am being asked to read the following material to ensure that I am informed to the nature of the screening service. Signing this form will indicate that I have been so informed and that I give my consent.

Procedures

- **Hypertension** (high blood pressure); I consent to the measurement of my blood pressure using a blood pressure cuff (sphygmomanometer).
- **Diabetes** (high blood sugar); I consent to the measurement of my blood sugar using a blood glucose meter (glucometer).

*Based on the results of these screening, the screener **MAY** contact my physician with a recommendation for further evaluation*

Risks

If I agree to participate, I am aware that there are **NO** common serious risks. In obtaining blood from my finger, there may be temporary **tenderness** at the puncture site. There is a **rare** chance the puncture may lead to an **infection** at the sample site on the finger.

Confidentiality

By signing this consent form, I allow the screeners involved to use my screening and patient care data for analysis and reporting. Data will be analyzed and reported only by groups of patients who participate in various portions of this screening program. My name, address, and phone number will **NOT** be revealed.

Authorization

The procedure, risks and confidentiality issues have been explained to me and my questions have been answered.

Patient Signature

Date