Giant Pharmacy Blood Collection Informed Consent revised 12.20.24

Name:	**Date of Birth: / / Age: Gender:** F
Address:	**City: State:** VA **Zip Code:** 20171
Phone Number:	**Mobile Number:**
Primary Care Provider:	**Provider Phone Number:**
Provider Address:	**City: State: Zip Code:**

Pre-Screening Questions

If any questions are unclear, please ask for assistance.	YES	NO
1. Are you allergic to stainless steel, adhesives, glues, bandages, latex? If yes, please list:	☐	☐
2. Do any of the following apply to you**? (check all that apply)** ☐ Currently pregnant or may be pregnant ☐ **Current cancer or h**istory of cancer ☐ **Blood clotting disorder or currently taking blood thinners**	☐	☐
3. Do you have phobias around blood draws or have experienced dizziness, fainting, or loss of consciousness due to a medical procedure or health care??	☐	☐
4. Have you received biotin therapy in doses greater than 5mg/day in the last 8 hours or have taken a biotin supplement in the last 24 hours?	☐	☐
5. **The blood collection service provided by the pharmacy is being performed for my convenience and is not a substitute for care of a physician or hospital. Do you have any questions about the service provided by the pharmacy?**	☐	☐

Informed Consent

I certify that I am at least **22** years old and I hereby give my consent to the staff of Giant Pharmacy for collection of blood to submit to 20/20 GeneSystems Lab., I understand that, as with any medical test, there is the potential for a false positive or false negative result. I further understand that Giant Pharmacy and the testing unit is not acting as my medical provider, this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regard to my test results. Specifically, I understand that I am assuming the risk associated with blood draws including, but not limited to fainting and anxiety. I agree that it is my obligation to seek medical advice, follow-up care, diagnosis and/or treatment from my medical provider if I have questions or concerns, and to follow-up on test results, or if my condition worsens. I have had the opportunity to ask questions about the services received at the pharmacy, the associated risks and benefits. All my questions have been answered to my satisfaction. I authorize the pharmacy staff to send copies of my results to the appropriate public health authorities (including State Registries, Depts. of Health, and/or CDC). I hereby release Giant Pharmacy from any liability related to processing the test or the test results after the test is shipped from Giant Pharmacy's location to the lab for analysis. I hereby release Giant Pharmacy and its parent, subsidiary and affiliates, and its officers, employees and agents, respectively, from any and all liability that might arise from these results on behalf of me, my heirs and personal representatives. I acknowledge I have the right to ask for a copy of the Giant Notice of Privacy Practices.

Patient Date of Birth (MM/DD/YYYY): _____ **Patient Age: _____ years**

_____ **_____**

Patient Name (Please Print) **Patient Signature** **Date (MM/DD/YYYY)**

_____

Legal Guardian **Legal Guardian Signature** **Date(MM/DD/YYYY)**

PHARMACY USE ONLY SECTION

Specimen Order # (on requisition form):_____
Specimen Type: Whole Blood capillary
Specimen Collection Date & Time:_____
Collected from (*circle one*) LEFT or RIGHT outer upper arm

Lancet Lot: _____ Lancet Exp: _____
CT* Lot: _____ CT* Exp: _____
*CT = collection tube

Post-collection Specimen Tube Checklist:

- **Labeled with patient full name and DOB _____ (initial)**
- **Sample shipped on collection day _____ (initial)**

Specimen Pick-up Date & Time: _____

Pharmacy Name: Giant #_____ Address: _____ Phone Number: _____

Lab Name: Genesys Biolabs CLIA #: 21D2037411 CLIA Exp Date: 11/01/2026

Address: 15810 Gaither Drive Suite 235, Gaithersburg, MD 20877 Phone Number: (240) 453-6339