McLaren
CARO REGION

NON-MEDICAL BLOOD DRAWS

Account #: _____

Last	First	M.I.	Date	Time AM PM

DOB	Age	Phone Number	Marital Status □ M □ S □ W □ D □ Sep	Sex □ M □ F

Address	City	State	Zip Code

BOX A/B- NOT Under Arrest _____ Nurse Initials

I, _____, (Print Name), am not under arrest and voluntarily consent to have my blood drawn. I understand that it may be necessary to be tested for a serious communicable disease such as AIDS, ARC, HIV or Hepatitis without additional consent. This information will be used in the treatment of Hospital staff physicians and/or employees should they be subject to a skin puncture, mucous membrane or open wound exposure, to my blood or other body fluid. I understand that I will be responsible for payment of this service.

_____ _____
Signature Date

_____
If Parent or Legal Guardian, Print Name

I have asked the above individual and confirmed he/she ☐ *does* or ☐ *does not* have hemophilia, diabetes or take anticoagulants/blood thinners. _____ _____
Nurse Signature Date

BOX C- Under Arrest_____ Nurse Initials

I attest that I do have hemophilia, diabetes or take anticoagulants/blood thinners and consent to have my blood drawn. I understand that it may be necessary to be tested for a serious communicable disease such as AIDS, ARC, HIV or Hepatitis without additional consent. This information will be used in the treatment of Hospital staff physicians and/or employees should they be subject to a skin puncture, mucous membrane or open wound exposure, to my blood or other body fluid.

_____ _____
Signature Date

_____
If Parent or Legal Guardian, Print Name