

**FWHC**

**CONSENT FOR WELLNESS SERVICES**

**Please read and sign below if you have an appointment with the nurse practitioner today:**

I consent to care and treatment at the FWHC. I understand that I will be seen by a nurse practitioner. I also understand that all or part of my accessory health services will be provided by trained health workers.

If the nurse practitioner finds anything beyond the scope of her practice and/or experience during my examination, I understand that I may be referred to a physician or other facility. I understand that the nurse practitioner may consult with a collaborating physician by telephone. I understand that if my situation warrants a referral to another health care provider, I shall be solely responsible for making those arrangements and for any fees associated with the healthcare I receive.

\_\_\_\_\_

Client Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Staff Signature

\_\_\_\_\_

Date



**CONSENT FOR LABORATORY SERVICES**

**Please read and sign below if you do not have an appointment with the nurse practitioner today and will be receiving laboratory testing:**

I consent to laboratory testing at the FWHC. I understand that the interpretation of any laboratory test results should be made only by a licensed health care provider as factors unclear to the lay person may exist.

Because the implications of laboratory testing results can be complex, involving medical, emotional and social issues, some results will only be reported to the client in person and so will require a follow up visit. Laboratory test results and patient information are confidential and will only be released to you, the client. You will need to sign a request for release of medical records if you want your results mailed or faxed to another health care provider.

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Client Signature

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Date

\_\_\_\_\_

Staff Signature

\_\_\_\_\_

Date