

This screening helps  
identify current or potential  
health problems.  
Tests allow the detection of many  
medical problems including:

#### ANEMIA

Red Blood Cell Count  
White Blood Cell Count  
Hemoglobin  
Hematocrit  
Platelet Count  
Red Blood Indices  
(MCV, MCH, MCHC)

#### LIVER DISEASE

Albumin  
Total Bilirubin  
Total Protein  
SGOT  
SGPT  
Alkaline Phosphatase

#### DIABETES

Glucose

#### CORONARY/HEART DISEASE

Cholesterol  
Triglycerides  
HDL  
LDL

#### KIDNEY DISEASE

Bun  
Creatinine  
GFR

#### OTHER TESTS

Calcium Chloride  
Potassium  
Sodium  
Prostate Screening (males only)  
PSA  
Anion Gap



## **BLOOD SCREENING PROGRAM**

Sponsored by The Winter Garden Rotary Club  
Lab Services provided as a community benefit by Health Central Hospital

**THURSDAY, MARCH 28, 2019**

Hours: 7:00 a.m. - 10:00 a.m.

Performed in the Auxiliary Central Meeting Room at Health Central

This early warning health test will be provided  
at a low cost to our community.  
(Limited tests available, please pre-register)

**\$50 .00 PRE-REGISTERED • \$60.00 WALK-INS**

*Fees include entire process, including:*

- Collection of blood sample
- Analysis
- Confidential reporting directly to you

#### **FASTING:**

**Nothing to eat or drink (except water) for the previous eight (8) hours required.**

#### **PRE-REGISTRATION:**

Form must be received by Monday, March 25, 2019.  
Complete the attached form and return with your check  
in the amount of \$50.00\* payable to:

**Winter Garden Rotary Club**  
c/o Health Central Hospital  
Attn: Dawn Willis  
10000 West Colonial Drive  
Ocoee, FL 34761

**Questions? Call 407-296-1770**

#### **MAIL THIS Registration Form**

Must be received by Monday, March 25, 2019

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: ( \_\_\_\_\_ ) \_\_\_\_\_  
Email address: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Male: \_\_\_ Female: \_\_\_  
SS# (optional) \_\_\_\_\_  
Family Physician: \_\_\_\_\_

#### **KEEP THIS form and present to:**

**Auxiliary Central Meeting Room at Health Central**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Male: \_\_\_ Female: \_\_\_  
Hospital requires your SS#: \_\_\_\_\_  
A gift from: \_\_\_\_\_

*This is a laboratory  
screening test. It  
may or may not  
alert you and your  
doctor to a serious  
medical problem.  
The results of this  
test are not intended  
to substitute for your  
doctor's diagnosis  
and treatment.*

**REMEMBER TO FAST**

**HEALTH INSURANCE** \_\_\_ YES \_\_\_ NO