

**University of Louisiana at Monroe
School of Pharmacy
Patient Consent Form**

Name: _____
____/____/____
 (First) (MI) (Last)

Today's Date: ____

Age: _____ years old

Birth date: ____/____/____

Race:

Smoker: ☐ Yes ☐ No

Fasting: _____ (Yes, if you have not had anything to eat or drink in the last 8 hours other than water or black coffee.)

CONSENT TO PERFORM LABORATORY TESTING

The above information is true to the best of my knowledge. I authorize the University of Louisiana at Monroe to perform finger-stick blood testing. I understand that I am financially responsible for any fees to perform this service.

Date: _____

Patient

Signature: _____