

Dear

You are scheduled for your Ongoing Fernald Medical Monitoring Program Examination and Testing on _____ at _____ a.m. Enclosed is a map to assist you in finding our Mercy office. Enclosed is an information sheet to read. A copy of the Informed Consent you will be asked to sign is provided in this packet for you to read and review. Lastly, enclosed is your Information Update and other forms to fill out and bring back with you to your appointment.

The visit will take approximately 2 1/2 hours except women having mammograms will have visits that take approximately 3 1/2 hours. After you sign your Informed Consent, you will have your blood drawn and urine specimens will be obtained from adults 45 years of age and older. You will then have your physical examination by a Board Certified physician. Women eligible for mammograms will have this test.

You will receive a letter sent by first class mail from the physician explaining your results within 6-8 weeks of your visit.

If you have any questions, please contact the Mercy office at 860-0891. We look forward to your participation in this program.

Sincerely,

THE FERNALD MEDICAL MONITORING PROGRAM

Dear FMMP Participant,

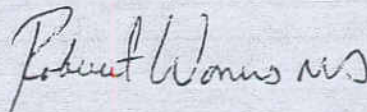
It's time to schedule your Ongoing Re-Examination with the Fernald Medical Monitoring Program (FMMP). Please call the Mercy Fairfield office weekdays between 11 am and 4 pm at 860-0891 to schedule your appointment. Please tell the secretary you are calling to schedule your ONGOING RE-EXAMINATION.

You will be offered:

1. A physical examination of your skin, thyroid gland, lymph nodes, mouth, heart, chest, and abdomen.
2. Blood tests for cholesterol, kidney function, blood sugar, and red and white blood cell counts.
3. Rectal exam, urine tests, and testing of the stool for blood for adults 45 years of age and older.
4. PSA (Prostate Specific Antigen), a screening test for prostate cancer for men 50-79 years of age.
5. Pap smears for adult women.
6. Mammograms yearly for women 50 years of age and older and every other year for women between the ages of 40-49.

We hope you will choose to take advantage of this opportunity. Your continued participation in the FMMP is important for you, for the Program, and for the class.

Sincerely,



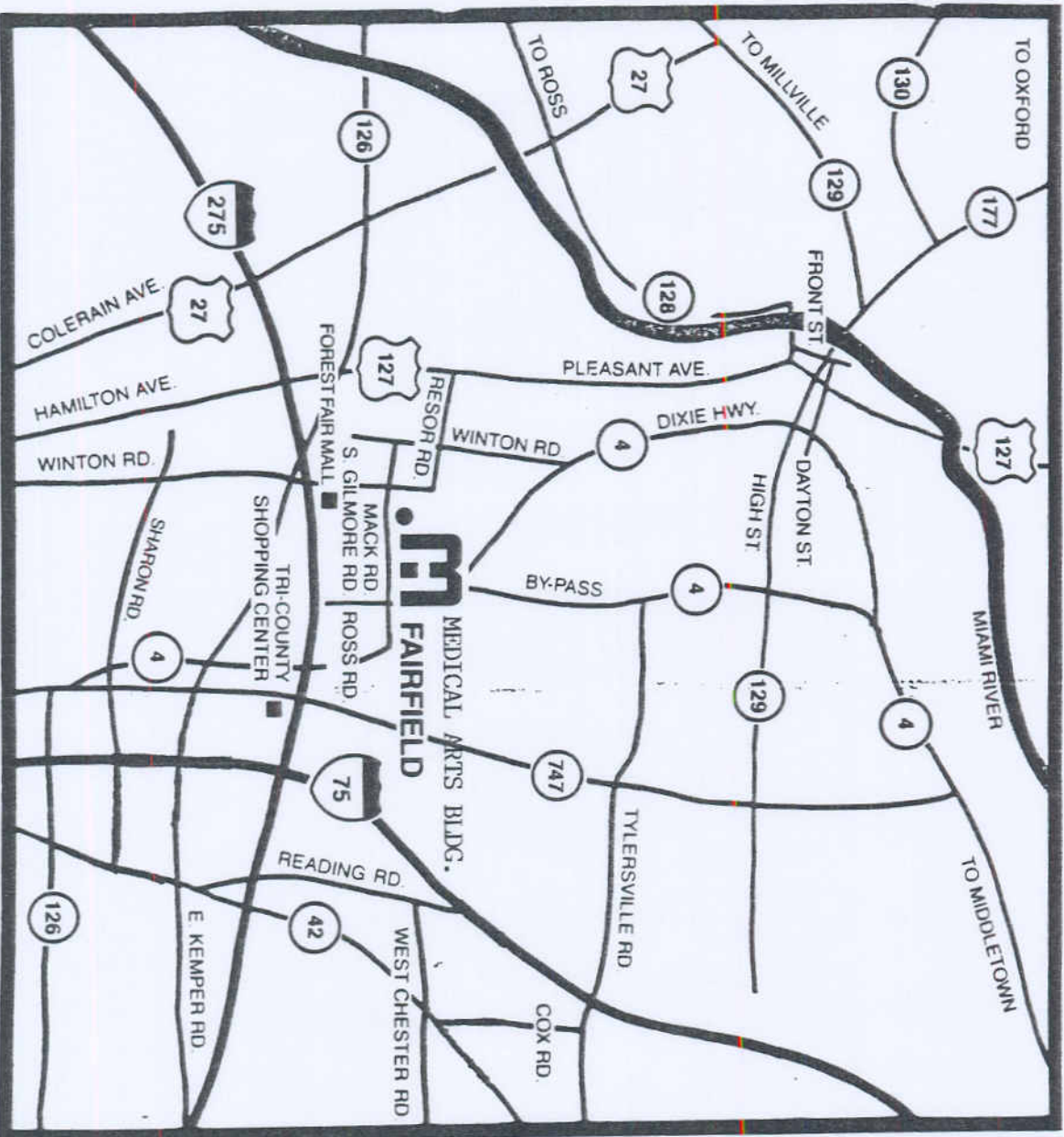
Robert Wones, M.D.
Program Director

FERNALD MEDICAL MONITORING PROGRAM
ONGOING MONITORING PROGRAM 1994

INFORMATION AND INSTRUCTIONS
FOR PARTICIPANTS

1. PLEASE REMEMBER YOU NEED TO FAST FOR YOUR BLOOD DRAW. Fasting is important when measuring your blood sugar and triglyceride levels (a blood fat). Please do not eat or drink anything for 10 hours before your scheduled appointment time. Coffee, juice, and a snack are available after we obtain your blood.
2. Please wear clothes that are easy to slip on and off for your physical examination.
3. Please review your immunization records. The physician will ask when you had your last tetanus shot, measles shot, etc.
4. Please call the Mercy office at 860-0891 if you must cancel your appointment. We must have 48 hours notice. If you do not show for two appointments, you will not be rescheduled for a third appointment.
5. Physicians and staff in the Medical Monitoring Program cannot fill out school or work physical examination forms or other physical examination forms for licenses or insurance.
6. Free parking is available in front of the Mercy Fairfield Medical Arts Building, 2960 Mack Road. If you have any questions, please call the Mercy office at 860-0891.
7. For questions about obtaining your Fernald Medical Monitoring Program records and results, chest X-ray reports and/or films, mammogram reports and/or films, or any other test report or paper in your record, please call the UC office at 241-1628.

DIRECTIONS FOR MERCY HOSPITAL MEDICAL ARTS BUILDING



* U.S. 27 (Colerain Ave.) South,
 275 East to Forest Park/Greenhills
 Exit (Exit 39), left at exit ramp
 onto Gilmore Rd., right on Mack Rd.,
 hospital is on the left.

* ROSS/VENICE AREA
 U.S. 27 (Colerain Ave.) South,
 (crossing the Miami River), left
 at Ohio Route 126 (Kemper Rd.),
 continue East on Kemper Rd. to
 Winton Rd., left (North) on Winton
 Rd., right on Mack Rd., hospital is
 on the left.

* I75 or I71
 275 West to Forest Park/Greenhills
 Exit (Exit 39), right at exit ramp
 onto Gilmore Rd., right on Mack Rd.,
 hospital is on the left.

U.C. CODE # _____

ONGOING MONITORING PROGRAM
FERNALD MEDICAL MONITORING PROGRAM

RELEASE TO SEND RESULTS TO PRIVATE PHYSICIAN

Please send a copy of the results (summary letter, examination, and test results) of my participation in the Program of the Fernald Medical Monitoring Program to my private physician.

Send all results

Send only _____

Physician's name: _____			
Address: _____		Phone # _____	
_____	_____	_____	_____
City	State	Zip	Code
INCOMPLETE MD ADDRESS MAY RESULT IN DELAY IN SENDING RESULTS			

As a participant of the Program, I will receive by regular mail a letter summarizing my examination and test results. I would like to have a copy of:

my summary letter only

my summary letter and copy of the examination and test results

Participant signature: _____ / ____ / ____
Name Date

Print Participant Name: _____

Date: ____ / ____ / ____

Witness: _____

Authorization for Release of Information
to the Fernald Medical Monitoring Program

The purpose of this form is to allow you to give permission for release of your medical records to the Fernald Medical Monitoring Program. Please complete the information below. The program will then send this release to the hospital or physician you have named.

Patient Name: _____
Last First

Address: _____

Birthdate: _____ / _____ / 19 ____ SS#: _____ - _____ - _____
City State Zip Code

I hereby authorize release of the following information from my medical records from:

Hospital or Physician _____ Phone Number _____

Address _____

City _____ State _____ Zip Code _____

INCOMPLETE PHYSICIAN ADDRESS MAY RESULT IN DELAY IN SENDING YOUR RESULTS

Information regarding: _____ date
_____ Chest X-ray results from _____ / _____ / _____
_____ Mammogram Results from _____ / _____ / _____
_____ Pap Smear Results from: _____ / _____ / _____
_____ Other _____ / _____ / _____

The Purpose of the Request for Information: The patient is participating in the Fernald Medical Monitoring Program and the information requested above is needed to avoid unnecessary duplication of tests or confirm the patient's diagnosis.

THIS CONSENT must be signed and dated and is valid for ninety (90) days after the date of my signature or as I have otherwise specified below (date of event upon which consent will expire if less than 90 days): THIS CONSENT may be revoked at any time to the extent action has not been taken prior to revocation.

MY SIGNATURE indicates that I have read and fully understand the above statements. I hereby consent to the disclosure of the medical records to the purpose and extent stated above.

SIGNATURE _____ DATE _____

FOR PHYSICIANS USE ONLY: Fernald Medical Monitoring Program
2060 Reading Road, Suite 220
PLEASE SEND RECORDS TO: Cincinnati, OH 45202
Attn: Sandy Sahnd