BIOMETRIC HEALTH SCREENING FORM

Dear Physician/Provider- I am participating in the Lakemary Center Employee Wellness program and have agreed to complete a biometric health screening. The following form needs to be completed as part of my personal health assessment and will need to be provided to Lakemary Center Employee Wellness to earn additional incentives. **Please complete Section 2 and fax to (913) 359-5424 or email to grace.davis@lakemary.org.**

SECTION 1: To be completed by you, the employee.

______________________	______________________	______________________
Last Name	First Name	Birth Date (MM/DD/YYYY)
(_____)____________________	______________________________	
Phone Number	Email Address	

Please read and sign the following disclosure statement: I consent to the release of my biometric screening data to Lakemary Center Employee Wellness for the purpose of providing follow-up health education and data aggregation for program improvements. I understand that the collection of my health information is voluntary and that my medical information will remain confidential and protected as required by law under the Health Insurance Portability and Accountability Act (HIPAA). In addition, I understand that this form is to be completed and received by Lakemary Center Employee Wellness before any incentives are granted.

Participant Signature: ____________________________________ Date: ________________

SECTION 2: To be completed by your physician/ provider.

Collection Date: _____/_____/________	Blood Pressure: _____/_____ mmHg
Gender (Circle): Male Female	Pulse: _______ bpm
Height: _______ ft. _______ in.	**Blood Panel:** LDL: _______ mg/dL
Weight: _______ lbs.	Total Cholesterol: _______ mg/dL HDL: _______ mg/dL
BMI: _______ kg/m^2	Glucose: _______ mg/ dL OR A1c: _______ mg/dL
Waist Circumference: _______ in.	Fasting Status (Circle): Fasting Non-Fasting
Pregnant (Circle): Y / N / NA	

By signing below, I certify that the participant, as listed above, has been seen in my clinic on or after April 1, 2024.

Physician/Provider's Signature: ________________________________ Date: ______________

Physician/Provider's Name (Printed): ____

Office Phone Number: (_____)______________ Address: ____________________________