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: _____/_____/_____

Gender (Circle): Male Female

Height: _____ ft. _____ in.

Weight: _____ lbs.

BMI: _____ kg/m^2

Waist Circumference: _____ in.

Pregnant (Circle): Y / N / NA

Blood Pressure: _____/_____ mmHg

Pulse: _____ bpm

Blood Panel: LDL: _____ mg/dL

Total Cholesterol: _____ mg/dL HDL: _____ mg/dL

Glucose: _____ mg/ dL OR A1c: _____ mg/dL

Fasting Status (Circle): Fasting Non-Fasting

By signing below, I certify that the participant, as listed above, has been seen in my clinic on or after April 1, 2025.

Physician/Provider's Signature: _____ Date: _____

Physician/Provider's Name (Printed): _____

Office Phone Number: (_____)_____ Address: _____