PHYSICIAN FORM FOR BIOMETRIC SCREENINGS

Cost: This is a company paid benefit. You will receive xxxx for participating.

**During your preventive exam and biometric screening, done at your physician’s office, you will need to make sure you have the below tests completed. Tests must have been done between 4/1/15 and Mar 1, 2016 or later to qualify for the premium discount, not to exceed 14 months between exams.**

**Name (First/Last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **If Spouse of LPR employee, check here**

**Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **BLOOD PRESSURE: SYSTOLIC (TOP NUMBER): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DIASTOLIC (BOTTOM NUMBER): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **HEIGHT (FEET AND INCHES): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **WEIGHT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **GLUCOSE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_mg/dL**
4. **TRIGLCYERIDES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_mg/dL**
5. **TOTAL CHOLESTEROL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_mg/dL**
6. **LOW DENSITY LIPOPROTEIN (LDL): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_mg/dL**
7. **HIGH DENSITY LIPOPROTEIN (HDL): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_mg/dL**
8. **Physician please ask the following: Please circle:**

**Have you used tobacco in the last 90-days? YES NO**

**Tobacco includes cigars, cigarettes, chewing tobacco, pipe tobacco, or any other tobacco product. FDA approved Nicotine replacement therapies (NRT) are not considered tobacco usage.**

*Physician Name (printed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Physician Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***FAX THIS FORM TO PREVENTIVE HEALTH NOW, LLC AT 720-398-9204***

***YOU MUST PROVIDE A COPY OF YOUR LAB RESULTS FROM YOUR DOCTOR’S***

***OFFICE***

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