Indiana University Health

2015 PHYSICIAN OPTION FORM

The patient's physician or medical provider must fax this completed form to the Health and Wellness Center at Washington Township at 317-259-5363

Please have your provider complete this form to report the values of your biometric screening (blood pressure, height, weight, BMI, waist size/circumference, fasting glucose, A1C and Lipid Panel [TC/HDL Ratio, Total Cholesterol, LDL Cholesterol, HDL Cholesterol and Triglycerides]).

PARTICIPANT COMPLETE THIS SECTION ONLY

_____ _____ _____ ____/____/_____

Last Name (Printed) First Name (Printed) MI Date of Birth (mm/dd/yyyy)

Address: _____ Phone Number: _____

Email: _____ Gender: ☐ Male ☐ Female

Employer: _____

Pregnant or Post-Partum (up to one year)

☐ Pregnant ☐ Post-Partum Delivery Date: ____/____/_____

THIS SECTION TO BE COMPLETED BY SCREENING PERSONNEL AND/OR MEDICAL PROVIDER

Date of Testing ____/____/_____

Blood Pressure: _____ Height (inches): _____ Weight (lbs.): _____ BMI: _____ Waist Size/Circumference: _____

Fasting Glucose: _____ TC/HDL Ratio: _____ Total Cholesterol: _____ A1C: _____

Triglycerides: _____ HDL Cholesterol: _____ LDL Cholesterol: _____ Fasting: ☐ Yes ☐ No

(Optional) Physician Notes:

Provider's Signature: _____ Date: ____/____/_____

Provider's Name (Printed): _____ Phone Number: _____

Consent information: This information, along with any personal health information provided in completing the Health Assessment, is maintained in a secure area within IU Health to be used only for calculating this incentive. It is not shared with your employer. IU Health will provide your employer aggregate information as part of a group summary report (individual data results will not be disclosed.) IU Health uses some of its subsidiaries, affiliates, and other agents to carry out the work of its wellness program.

To the extent it is necessary, I hereby consent to such release for these agents, employees and/or clinical providers of IU Health to have access to my health screening information in order to carry out their duties. **By submitting this form, I hereby consent to use of my biometric screening information for the purposes specified above, and grant any wellness program associate permission to contact me regarding my results.**

FOR OFFICE USE ONLY

Date Fax Received: ____/____/_____ Date Entered: ____/____/_____ Date Verifed: ____/____/_____