UAB EMPLOYEE WELLNESS

The University of Alabama at Birmingham

Health Care Provider Health Screening Instructions

HealthSmart

- PARTICIPANT – Complete section 1
- HEALTH CARE PROVIDER – Complete section 2 and fax completed form to HealthSmart: **(205) 996-2974**

SECTION 1: PARTICIPANT INFORMATION – Print clearly. Illegible forms will not be processed.

Participant's Date of Birth (MM/DD/YYYY) / / Gender M F Blazer ID

Participant's First Name MI Participant's Last Name

Address Unit / Apt

City State Zip Code

Email Address

Phone Number - -

Disclosure Statement: My individually identifiable health information will not be shared with my Employer; however my Employer may be advised of the fact of my participation in this health screening for purposes of qualification for incentives offered by my Employer. In addition, if my Employer offers incentives related to "pass/fail" test results, my "pass/fail" test results may be disclosed to my Employer for those incentive purposes. My health screening test results may be disclosed to vendors engaged by my Employer or Employer- sponsored group health plan for purposes of determining my eligibility for an incentive related to this health screening, for health management and/or disease management services including data aggregation for program improvement purposes, and/or for purposes of population of my Personal Health Record available online and/or my Health Risk Assessment (HRA). The importance of safeguarding individually identifiable health information is recognized and all organizations involved are obligated to take reasonable steps to protect such information from unauthorized access or use.

Participant's Signature: _____ Date:

PATIENTS: Biometric Screening must be submitted by 08/16/2017. Measurements will not qualify if taken prior to 11/14/2016. This form must be completed in its entirety, accurately and legible in order to be deemed complete.

SECTION 2: HEALTH SCREEN RESULTS – Physician or office staff use only below this line.

HEALTH CARE PROVIDER: *UAB* is offering a voluntary wellness program to encourage participants to understand their health risk. **uab.edu/wellscreens**

Blood Panel

Total Cholesterol: HDL: TC/HDL Ratio:

Glucose: LDL: TG:

Fasting Status

Fasting:

Non-Fasting:

Blood Pressure

Systolic

Diastolic

Body Composition

Height ft in BMI

Weight Lbs. Body Fat%

Pulse

Tobacco Use

Yes

No

Females Only

Currently pregnant or pregnant in the last 12 months

Yes No

Facility Name: _____

Phone Number: _____

Health Care Provider's Name: _____

Physician's Signature: _____

Date of Service / Test: _____

Please fax completed form to HealthSmart:
(205) 996-2974
by deadline 08/16/2017.

Date Faxed:

NOTICE: Any form submitted incomplete, inaccurate or not legible will be deemed invalid.