Preventive and Biometric Screening Confirmation Form

WHY THIS ACTIVITY IS IMPORTANT

Preventive and biometric screenings are used to identify individuals who may have risk factors for heart disease, diabetes, metabolic syndrome and more. Typically, you will have measurements for blood pressure, waist circumference, glucose (sugar), triglycerides (fat) and HDL (your good cholesterol.) Finger-stick technology enables accurate analysis and immediate results. These results are shared by a health professional with each individual on a confidential basis and include recommendations on how to reduce risk factors, which may include follow-up care or lifestyle changes. Your employer may also offer various disease intervention programs and preventive measures to help you reduce these risks. If you are free from these risk factors, you will be given a thumbs up and encouraged to keep up the good work of managing your health … keep doing what you've been doing!

Many employees will find that annual biometric health screenings can have a tremendously positive impact on their health, productivity, and well-being. When aware of these findings, employees are more likely to take a proactive role in their health and lifestyle changes.

ACTION YOU NEED TO TAKE

This activity will require you to visit your Primary Care Physician for an annual check-up and receive the necessary biometric screenings below.

INSTRUCTIONS TO MEMBER

To complete the annual check-up and biometric screening activities and earn HSA credit, this form must be completed in full. Forms submitted without a provider stamp/signature will not be accepted.

Follow the guidelines below to ensure completion:

- Data cannot be self-reported. A provider stamp or documentation must be provided.
- If necessary, only attach the required information, not a complete physical summary.
- Prior to turning in or sending this completed sheet, please make a copy for your records.

Once this form has been completed by your provider, turn it in to receive credit.

INSTRUCTIONS TO PROVIDER

Please screen this member for the following markers and share the results with the member. Once complete, stamp (or sign) and date this form to verify that the member has had the tests completed and understands their results.

☐ Biometric Screening

- Waist Circumference
- Triglycerides
- Blood Pressure
- Glucose
- HDL Cholesterol

☐ Annual Physical

PRINT PATIENT NAME: _____

Provider Stamp	*Date of Completion*

Tests 100% preventative and paid for is based on your plan coverage.
Please reach out to your specific insurance carrier with any questions.

Preventive Screening Confirmation Form

WHY THIS ACTIVITY IS IMPORTANT

Preventive screenings are an important part of health promotion efforts. We recognize that the more aware employees are of their health, the more motivated they'll be to change. Preventive screenings are an important step to identify and treat potential health problems before they develop or worsen.

ACTION YOU NEED TO TAKE

This activity will require you to visit your Primary Care Physician for an annual check-up and receive the necessary age-and gender-specific preventive screenings.

INSTRUCTIONS TO MEMBER

To complete the annual preventive screening activity and earn credit, this form must be completed in full. Forms submitted without a provider stamp/signature will not be accepted.

Follow the guidelines below to ensure completion:

- Data cannot be self-reported. A provider stamp or documentation must be provided.
- If necessary, only attach the required information. Do not attach test results or a complete physical summary.
- Prior to turning in or sending this completed sheet, please make a copy for your records.

Once this form has been completed by your provider, turn it in to Human Resources to receive credit.

INSTRUCTIONS TO PROVIDER

Please authorize the following recommended preventive screening(s) for this member, based on age, gender and health history. Once the screening is completed, stamp or sign this form to verify the member has completed the test and understands the results.

- ☐ Colorectol Cancer Screening (colonoscopy)
- ☐ Breast Cancer Screening (mammogram)
- ☐ Cervical Cancer Screening (Pap test)
- ☐ Testicular and Prostate Cancer Screening (DRE and PSA)
- ☐ Other (please specify) _____

PRINT NAME: _____

Provider Stamp	*Date of Completion*

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