1675 N. Barker Road, Ste 200 Brookfield, WI 53045 Toll Free: 1-866-814-1016 Fax: 262-754-0067

BioScreen Physician Results

If you are unable, or choose not to participate in the InHealth BioScreen offered at SASD you may submit results from your physician, providing that they have been collected between March 14th and July 14th. We strongly recommend that you submit results from a fasting blood draw; glucose and cholesterol levels are impacted by short term food consumption. If you currently take medication(s) please follow your physician's or pharmacist's recommendation in regard to fasting. Please mail or fax all results directly to *Interra Health*™. **The deadline to submit these results is July 14th, 2017.**

! In order to receive credit for your submitted results:

- **You cannot be missing more than two of the requested values. All values must be recorded below.**
- **A printout of your blood lipid profile results must be attached to this form. You may need to request this from your clinic or physician.**
- **Interra Health must receive your results by the deadline listed above.**
- **Points will not be awarded for any missing values.**

Participant Name: ____ □ Employee □Spouse

Employer Name: **SASD**

Facility Name (Required):	
Physician Name (Required):	
Facility Phone Number (Required):	Total Cholesterol:
Height:	HDL:
Weight:	LDL:
Blood Pressure:	Triglycerides:
Waist Circumference:	Glucose:
Body Mass Index (BMI):	TC/HDL Ratio:

Please answer the following questions:

1. Do you use tobacco products? ☐ Yes ☐ No
2. Do you take cholesterol medication(s)? ☐ Yes ☐ No
3. Do you take blood pressure medication(s)? ☐ Yes ☐ No
4. Were you fasting for your blood work? ☐ Yes ☐ No
5. Are you pregnant? ☐ Yes ☐ No

HIPAA Release

I hereby authorize *Interra Health*™ and any *Interra Health*™ staff member to make an inquiry on my behalf regarding the information I have provided on this BioScreen Physician Results form. I further authorize the disclosure of any information governed by HIPAA that may be necessary in order to provide the verification necessary in regard to the information I have provided for the purpose of my participation in a wellness program with *Interra Health*™. I understand that I will hold harmless any agencies providing information pursuant to this release of information, as well as *Interra Health*™ and any of its affiliates and employees in these matters.

I attest that the information I have submitted is true and correct to the best of my knowledge.

____ ______________________

Participant Signature Date Signed

For Office Use Only

_______ Entered _______Date Entered ☐ Online ☐ Data Entry File