THE OHIO STATE UNIVERSITY
HEALTH PLAN

# Biometric Health Screening Form

Dear Physician/ Provider:

I am participating in the Ohio State University wellness program. I have agreed to complete a biometric health screening. These numbers are needed to complete part of my Personal Health & Well-Being Assessment (PHA) and will need to be provided to OSUHP to earn additional incentives. Please complete Section 2 below and fax the completed and signed form to OSUHP by November 30, 2016.

SECTION 1: TO BE COMPLETED BY YOU, THE MEMBER (Please Print)

_____ _____

**Last Name***

**First Name** (Legal Name)*

_____

**Birth Date** (MM/DD/YYYY)*

**Best way to reach you with questions, please include at least one of the following:**

Phone: (_____)_____

Email: _____

* Indicates a required field

**Please read and sign the following disclosure statement**: I understand that my biometric screening data will be released to OSUHP for the purposes of follow-up health education and disease management, data aggregation for program improvement purposes, and/or for the purposes of updating my online PHA. I understand the collection of my health screening data is voluntary and my medical information will remain confidential and protected as required by law under the Health Insurance Portability and Accountability Act (HIPAA).

I further understand that this completed form must be received by OSUHP **no later than 5:00 PM EST on November 30, 2016**.

**Signature***: _____ **Date**: _____

SECTION 2: TO BE COMPLETED BY YOUR PHYSICIAN / PROVIDER

Exam Date: _____/_____/_____ Gender: Male Female

Height: _____ Feet _____ Inches

Weight: _____ Pounds

BMI:_____ Pregnant: Y / N / NA

Blood Pressure: _____/_____mmHg

Pulse: _____

BLOOD PANEL

**CHOLESTEROL**

Total Cholesterol: _____ mg/dl

HDL: _____ mg/dl

**GLUCOSE**

Fasting Status: ☐ Fasting

☐ Non-Fasting

Blood Glucose: _____ OR

A1c: _____

Physician/ Provider's Signature: _____ Date: _____

Physician/ Provider's Name (Please Print): _____

Office Phone number: ( ) _____ Address: _____

**Please fax completed form to OSU Health Plan at (614) 688-9670 by 11/30/2016**