Biometric Screening Physician Form

Orlando Health team members must have labs completed within the timeframe of December 1, 2016 - November 1, 2017. The form will not be accepted if incomplete (items that are left blank by you or your health care provider and not signed).

EMAIL completed form to: R-Biometrics@orlandohealth.com or FAX completed form to: 321.843.6346

NO LATER THAN November 17, 2017

Team Member ID:	**First Name:**	**Last Name:**
Date of Birth:	**Gender:** ☐ **Male** ☐ **Female**	**Location of employment:(ex. Health Central)**

Alternative Biometric Screening: I hereby authorize the medical health care provider and/or medical facility listed below to release the following biometric data to Healthchoice:

MEDICAL PROVIDER MUST COMPLETE AND SIGN THE INFORMATION BELOW

Date of Screening: _____ Fasting: Y / N

Height in Inches: _____ Weight in lbs. _____ BMI: _____ Blood Pressure: _____

Total Cholesterol: _____ Triglycerides: _____ Hemoglobin A1C*: _____

***A fasting blood glucose will not be accepted in place of a HbA1C**

Verification of Professional Care: If patient ranges are high and they are under your medical care please check the corresponding metric items below.

Section I.

I verify that _____ (patient name) is under my professional care for the management of the following condition (s):

☐ ***Hyperlipidemia***
- *Patient's cholesterol is 200 or greater* ☐ *Yes* ☐ *No*
- *Patient's triglycerides are 150 or greater* ☐ *Yes* ☐ *No*

☐ ***Hypertension*** *(BP 140/90 or greater); (BP 150/90 or greater for 65 and older patients)*

☐ ***Hemoglobin A1C***
- *Patient's A1C is 6.5 or greater* ☐ *Yes* ☐ *No*

☐ ***Overweight/ Obesity*** *(BMI greater than 24.9)*

- The patient is compliant to the treatment plan including diet, exercise and/or medications ☐ *Yes* ☐ *No*
- Patient's condition has not been responsive to diet, exercise and medication ☐ *Yes* ☐ *No*
- Patient is unable to tolerate medical treatment at this time ☐ *Yes* ☐ *No*

Section II.

☐ ***Pregnancy*** *- Patient should not be screened at this time due to pregnancy* ☐ *Yes*

Medical Provider's Name:_____ **Practice Name:**_____

Address: _____ **Telephone:**_____

Medical Providers Signature: _____ **Date:**_____

****Requirements: meet 3 out of 5 components below**	
• Blood Pressure: (Under 140/90); 65 yrs. or older (Under 150/90) • BMI: (24.9 and Under)	•HbA1c: (Under 6.5) •Triglycerides: (Under 150) •Total Cholesterol: (Under 200)

If you have any questions regarding this form please contact HR Solutions Center at 321.841.8623.