BIOSCREEN (LAB) RESULTS
FROM PERSONAL PHYSICIAN

Participant Name:______________________ Co-Worker ☐ Spouse ☐

Employer Name: **Cedarburg School District**

If you are unable, or choose not to participate in the InHealth BioScreen™ offered at Cedarburg School District, you may submit results from your physician, **provided that they have been collected between May 29, 2017 - September 30, 2017**. 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. You are responsible for ensuring that your results reach our office. You can also verify we have received your information on your To Do List on the Participant Dashboard.
The deadline to submit these results is September 30, 2017.

It is recommended that participants submit their documentation via the Secure Documents Center on the Participant Dashboard. Other options to submit documentation include fax (262.754.0067) or mail.

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.

Facility Name (required):	Phone Number (required):
***Physician Signature** (required):	Appointment Date (required):

Height:	Total Cholesterol:
Weight:	HDL:
Blood Pressure:	LDL:
Waist Circumference:	Triglycerides:
Glucose:	TC/HDL Ratio:

Please answer the following questions:

Do you use tobacco products?	Yes ☐	No ☐
Were you fasting for your blood work?	Yes ☐	No ☐
Are you pregnant? *see alternative form	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