



of South Central Wisconsin

Biometric Screening Form

FOR A HEALTHCARE CLINIC

MEMBER SECTION

Today's Date: _____ GHC-SCW Member Number: _____
 First Name: _____ Last Name: _____
 Date of Birth: _____ Gender: _____ Male _____ Female
 Phone: _____ Email: * _____
**providing an e-mail address gives GHC-SCW permission to use it to contact you*

EMPLOYER INFORMATION

The employer who is doing the wellness program

Name of Employer: _____
 Employer Address: _____
 Employer Phone: _____

I am voluntarily participating in these services. I hereby authorize my health care provider and any of their staff to enter the results in my medical record, and send this form to GHC-SCW's Wellness Department, for the purposes of the above employer's wellness program. I further authorize the disclosure of any information governed by the Health Insurance Portability and Accountability Act (HIPAA) that may be necessary in order to verify the information provided on this form. I understand that the employer listed above will receive my name as a participant, but will not receive my personal health information in any way that identifies me; but that my data may be included in group-level reporting. I understand that if I am going to my healthcare provider that my health plan benefits and associated rates may apply; and if I am going to an appointment for other medical reasons, and/or if any labs (blood work) are taken outside of the preventive health guidelines, that my benefits rates, including deductibles or co-insurance will apply.

Member Signature: _____ Date Signed: _____

HEALTHCARE CLINIC SECTION

Patient must get Height, Weight, BMI and BP every calendar year (the year that they are participating in their employer's incentive program). Labs are ONLY to be provided if the patient is due for them, based on the USPSTF preventive health guidelines. If patient is not due for them, please write in their last recorded values (if the data is available). **Patient must be given a copy of this biometric screening form with their results.**

BIOMETRICS

	<u>Requirement</u>	<u>Result</u>	<u>Date Taken</u>
Height:	Per calendar year	_____	_____
Weight:	Per calendar year	_____	_____
Body Mass Index:	Per calendar year	_____	_____
Blood Pressure:	Per calendar year	_____	_____
Waist Circumference:	Per calendar year	_____	_____

	<u>Preventive Guideline</u>	<u>[only perform new labs, if patient is due; if not, enter last recorded]</u>		
Lipids:	Age 18-21, once (non-fasting)			
	Age 22-75, every 5 years			
	Total Cholesterol:	_____	_____	___ Fasting or ___ Non-Fasting
	LDL Cholesterol:	_____	_____	___ Fasting or ___ Non-Fasting
Glucose:	Age 18-44, only if at-risk	HDL Cholesterol:	_____	___ Fasting or ___ Non-Fasting
		Triglycerides:	_____	___ Fasting or ___ Non-Fasting
	Age 45+, every 3 years		_____	___ Fasting or ___ Non-Fasting
			_____	___ Fasting or ___ Non-Fasting

Date when patient is due for next physical: _____

CLINIC STATEMENT – This can be filled out and signed by any healthcare clinic staff

I attest that I have (1) provided the patient with the biometric values above, and the labs were based on USPSTF guidelines; (2) explained results; (3) given recommendations for medical follow-up (if needed); (4) discussed lifestyle changes (if needed); and (5) informed the patient of any of their other care schedules.

Staff Name (please print): _____
 Signature: _____ Date Signed: _____
 Clinic Name & Address: _____
 Clinic Phone: _____ Lab Phone (if different): _____
 Lab Name & Address (if different): _____

SEND FORMS TO: GHC-SCW Wellness Department

P.O. Box 44971, Madison, WI 53744-4971; Fax: 608-662-4917; Email: wellness@ghcscw.com