WellScreens

Brought to you by UAB Employee Wellness

WELLSCREENS FAX FORM INSTRUCTIONS: UAB employee completes Section 1. Health care provider completes Section 2 and faxes completed form to Live HealthSmart, 205-996-2974. *Biometric screening must be submitted by 11/30/2024 to receive completion credit or incentive (if applicable).*

SECTION 1: PARTICIPANT INFORMATION (print clearly — illegible forms will not be processed)

Participant's Date of Birth (MM/DD/YYYY) / /

Sex: M F

Blazer ID

Participant's First Name

MI

Participant's Last Name

Address

Unit/Apt.

City

State

Zip Code

Email Address

Phone Number — —

Please read the following disclosure statement: I understand that my health screening data will be released to health plans associated with my company for the purpose of follow-up health education and disease management counseling (if eligible). My individually identifiable health information will not be shared with my Employer: however my Employer may be advised of the fact of my participation in this health screening for purposes of qualification for incentives offered by my Employer. In addition, if my Employer offers incentives related to "pass/fail" test results, my "pass/fail" test results may be disclosed to my Employer for those incentive purposes. My health screening test results may be disclosed to vendors engaged by my Employer or Employer- sponsored group health plan for purposes of determining my eligibility for an incentive related to this health screening, for health management and/or disease management services including data aggregation for program improvement purposes, and/or for purposes of population of my Personal Health Record available online and/or my Health Risk Assessment (HRA). The importance of safeguarding individually identifiable health information is recognized and all organizations involved in this Biometric Health Screening are obligated to take reasonable steps to protect such information from unauthorized access or use.

Participant's Signature: _____ Date: / /

SECTION 2: Health Care Provider only to complete below this line

Health Care Provider — UAB is offering a voluntary wellness program to encourage participants to understand their health risk. Measurements will not qualify if taken prior to 1/1/2023. This form must be completed in its entirety, accurately and legibly in order to be deemed complete. *Reminder to Provider: Are there any annual screenings your patient is now eligible for or needs a reminder about?*

Height: ft. in.

Weight: lbs.

BMI: .

Total Cholesterol:

Glucose:

A1C: (optional)

HDL:

Ratio:

Systolic Blood Pressure:

LDL:

TG:

Diastolic Blood Pressure:

Currently fasting? Yes No

Currently pregnant or pregnant in the last 12 months (♀only)? Yes No

75 to 150 minutes of physical activity each week, on average? Yes No

Facility Name: _____ Phone Number: _____

Provider's Name: _____ Date of Service/Test: _____

Provider's Signature: _____ Date: _____

Please fax completed form to Live HealthSmart at 205-996-2974 by 11/30/2024 (no exceptions).

NOTICE: Any form submitted incomplete, inaccurate or not legible will be deemed invalid.

UAB EMPLOYEE WELLNESS
The University of Alabama at Birmingham