Biometric Health Screening Provider Form

UNIVERSITY OF MINNESOTA
Driven to Discover℠

You have the option to attend an onsite University-sponsored health screening, or you may submit screening results collected by your health care provider within the last 6 months. Simply submit this form to your health care provider to complete, and return your completed form to StayWell by **August 31, 2012**. Submit a completed form to StayWell by the deadline and 100 points will be deposited into your Wellness Points Bank.

Completed by Participant:

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

First Name: ☐☐☐☐☐☐☐☐☐☐☐☐ **Male:** ☐ **Female:** ☐ **Employee:** ☐ **Spouse/Partner:** ☐

Date of Birth: ☐☐-☐☐-☐☐☐☐ (MM) (DD) (YYYY) **Employee ID number:** ☐☐☐☐☐☐☐☐☐

Consent to Use Information. I understand that StayWell may use personally identifiable information obtained on this Health Care Provider form, including, but not limited to, my name, my employee ID, my date of birth, and my biometric health screening results (my "Personal Information") to provide health management services to me, which includes using the Personal Information to inform me of relevant health related and health education programs offered by StayWell or by another service contractor. In the event that StayWell's services are transitioned to another service provider, StayWell may deliver my Personal Information to the successor provider to maintain a continuity of services for me. In order to distribute any incentives to me and/or to provide program participation information to the University of Minnesota, StayWell may provide my name, employee ID, and date of birth to the University of Minnesota or its designated representative to notify them of whether I am eligible for the incentive.

In addition to any Personal Information disclosed as set forth above, aggregate results, without any identifiable Personal Information, may be made available to the University of Minnesota for program reporting purposes. No individual biometric health screening results will be released to the University of Minnesota. StayWell and other contracted data analysis companies may also use my Personal Information as part of group statistical research and analysis. I also understand that my information may be entered into my Health Assessment results by StayWell. Except for these types of uses and the uses specified in my StayWell Online privacy policy/terms of use, my Personal Information will not be disclosed by StayWell.

I certify that the information supplied on this form has been provided to me by my health care provider, and I understand that StayWell may contact my health care provider listed below with questions regarding my information.

My submission of this form confirms that I agree to all of its terms and that I authorize StayWell to process my information accordingly.

Completed by Provider: **Date of Exam:** _____

Screening Exam	Patient Results	Desirable Range
Height – feet & inches	**Feet** **Inches**	
Weight – pounds		
Blood Pressure	/	Under 120/80 mm Hg
Total Cholesterol		Less than 200 mg/dL
HDL Cholesterol		Greater than 40 mg/dL
LDL Cholesterol		Less than 130 mg/dL
Total Cholesterol/HDL Ratio		Less than 3.5
Triglycerides		Less than 150 mg/dL
Glucose		Less than or equal to 140 mg/dL (non-fasting) 60- 99 mg/dL (fasting)
Fasting Status	☐ Fasting ☐ Non-fasting	
Health Care Provider Name		**Phone**

Requirements:

☐ **Complete** this form in full. Incomplete or late submissions of this form may delay or eliminate your patient from incentive eligibility.

☐ StayWell must receive this form by **August 31, 2012** using one of the following methods:

Mail to: StayWell Health Management
Attn: Screening Team
PO Box 21427
St. Paul, MN 55121

Fax to: 800-250-5197
*Please **do not** use a fax cover page*
**Allow 12-14 business days for processing.*

Office of Human Resources Wellness Program

Questions? Call the StayWell HelpLine at 866-341-1170.

StayWell Health Management