



2023 PHYSICIAN OPTION FORM - for City of Frankfort and Frankfort Utilities

The patient's physician or medical provider must fax this completed form to Associates Health Center at 765.605.4001. This form must be fax no later than October 27,2022.

Please have your provider complete this physical form and report the values of blood draw (blood pressure, height, weight, waist size/circumference, fasting glucose, A1C and Lipid Panel [Total Cholesterol, LDL Cholesterol, HDL Cholesterol and Triglycerides]). Only screenings that have been completed from January 1st, 2022 - October 27th, 2022 will be eligible to count towards the 2023 Incentive Program.

* The patient will receive an email from Associates Health Center confirming the receipt of this form within two weeks of submission. Should the patient not receive a confirmation it is the patient's responsibility to contact the clinic at 765.605.4000, and then follow up with their physician.

PARTICIPANT COMPLETE THIS SECTION ONLY

Form fields for participant information: Last Name (Printed), First Name (Printed), MI, Date of Birth (mm/dd/yyyy), Address, Phone Number, Email, Gender (Male/Female), Employer, Last 4 digit SSN.

Pregnant or Post-Partum (up to one year)
Pregnant Post-Partum Delivery Date: ___/___/___

Consent information: This information, along with any personal health information provided in completing the Health Assessment, is maintained in a secure area within IU Health to be used only for calculating this incentive. It is not shared with your employer. IU Health will provide your employer aggregate information as part of a group summary report (individual data results will not be disclosed.) IU Health uses some of its subsidiaries, affiliates, and other agents to carry out the work of its wellness program. To the extent it is necessary, I hereby consent to such release for these agents, employees and/or clinical providers of IU Health to have access to my health screening information in order to carry out their duties. By submitting this form, I hereby consent to use of my biometric screening information for the purposes specified above, and grant any wellness program associated permission to contact me regarding my results.

Signature of Patient: _____ Date: ___/___/___

THIS SECTION TO BE COMPLETED BY MEDICAL PROVIDER

Form fields for medical provider: Date of Screening ___/___/___, Blood Pressure: * <= 138/88, Height (inches):, Weight (lbs.):, Waist Size/Circumference:, Fasting Glucose: * <= 115, Total Cholesterol:, A1C:, Triglycerides:, HDL Cholesterol:, LDL Cholesterol: * <= 135, Fasting: Yes/No, Tobacco user: * Yes/No

* values required to meet 2023 incentive program

(Optional) Physician Notes:

Provider's Signature: _____

Date: ___/___/___ Provider's Name (Printed): _____

Phone Number: _____

FOR OFFICE USE ONLY
Date Fax Received: ___/___/___ Date Entered: ___/___/___ Confirmation Email sent by: _____ Date: ___/___/___