Indiana University Health

2020 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.

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 March 1, 2020 - October 31st, 2020 will be eligible to count towards the 2021 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 responsibililty to contact the clinic at 765.605.4000, and then follow up with their physician.*

PARTICIPANT COMPLETE THIS SECTION ONLY

_____ Last Name (Printed) _____ First Name (Printed) _____ MI ____/____/_____ Date of Birth (mm/dd/yyyy)

Address: _____ Phone Number: _____

Email: _____ Gender: ☐ Male ☐Female

Employer: _____ Last 4 digt 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, affliates, 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 pruposes 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

Date of Screening ____ /____ /_____

Blood Pressure: _____ Height (inches): _____ Weight (lbs.): _____

Waist Size/Circumference: _____ Fasting Glucose: _____ Total Cholesterol: _____

A1C: _____ Triglycerides: _____ HDL Cholesterol: _____

LDL Cholesterol: _____ Fasting: ☐Yes ☐No Tobacco user: ☐Yes ☐No

(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: ____/____/_____