## Primary Care Provider (PCP) Form - Biometric Screening

**FOTH COMPANIES** is authorizing your patient to have their biometric screening completed at your office with payment through their own insurance. The following information is needed to meet the requirements of participation in the screening:

**Date of Biometric Results:** ___________________________________

**Participant Information and Biometrics (to be completed by PCP)**

| | |
|---|---|
| Name | |
| Date of Birth | |
| Social Security Number (last 4 digits only) | |
| Best Contact Number | |
| Height | |
| Weight | |
| Blood Pressure | |
| Inches around waist at belly button to nearest ¼” | |
| Participant uses nicotine products (Yes or No) | |

**Blood Tests (to be completed by PCP - provide result for ALL tests listed)**

| | |
|---|---|
| Total Cholesterol | |
| LDL Cholesterol | |
| HDL Cholesterol | |
| Chol/HDL Ratio | |
| Triglycerides | |
| Glucose | |
| Hemoglobin A1c (Optional) | |

**PRIMARY CARE PROVIDER (PCP) -** contact Healics, Inc. at the number listed below if you have any questions regarding the blood test requirements.

___________________________________ ___________________________________

PCP Name (Printed) PCP Signature and Date

**PARTICIPANT-** Mail this form along with the health assessment questionnaire/Health Screening Program Consent and Authorization to:

Healics, Inc., ATTN: HRA Processing Dept
8919 W. Heather Avenue, Milwaukee, WI 53224 OR fax to 414-375-1639

Contact Healics with questions at 414-375-1600 or 800-432-5427