BIOSCREEN (LAB) RESULTS
FROM PERSONAL PHYSICIAN

Participant Name:_____ Participant B#:_____

Employer Name: Madison Metropolitan School District

If you do not participate in the InHealth BioScreen™ offered at MMSD, you may submit your biometric results from your physician, provided that they have been collected between July 1, 2017 - December 1, 2017. **The deadline to submit these results is December 7, 2017.**

How To Submit Results:

You are responsible for ensuring that your results are returned to Interra Health. You can confirm Interra Health has received your information on your To Do List on the Participant Dashboard.

- Upload documentation via the Secure Documents Center on the Participant Dashboard; OR
- Fax to (262) 754-0067 (keep your confirmation that the fax was sent successfully); or
- Mail to 1675 N Barker Road, Suite 200, Brookfield, WI 53045

Please answer the following questions:

Do you use tobacco products? YES NO
Were you fasting for your blood work? YES NO
Are you pregnant? YES NO

Biometric Screening Information:

Facility Name (required)				Phone Number (required)	
Physician Name (required)				Appointment Date (required)	
Height		Body Mass Index		LDL	
Weight		Waist Circumference		Triglycerides	
Blood Pressure		Total Cholesterol		TC/HDL Ratio	
Percent Body Fat		HDL		Glucose	

In order to receive credit for your submitted results, you cannot be missing more than two of the requested values.
We strongly recommend that you submit results from a fasting blood draw; glucose and cholesterol levels are impacted by short term food consumption. If you currently take medication(s) please follow your physician's or pharmacist's recommendation in regard to fasting.

Attestation and Signatures:

I attest that the information I have submitted is true and correct to the best of my knowledge.

Physician/Provider Signature: _____ Date Signed:_____

Participant Signature:_____ Date Signed:_____

HIPAA Release:

I hereby authorize Interra Health® and any Interra Health® staff member to make an inquiry on my behalf regarding the information I have provided on this BioScreen Physician Results form. I further authorize the disclosure of any information governed by HIPAA that may be necessary in order to provide the verification necessary in regard to the information I have provided for the purpose of my participation in a wellness program with Interra Health®. I understand that I will hold harmless any agencies providing information pursuant to this release of information, as well as Interra Health® and any of its affiliates and employees in these matters.

For Office Use Only

_____ Entered _____Date Entered ☐ Online ☐ Data Entry File

INTERRA® HEALTH

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