Physician Screening Collection Form

THIS FORM IS FOR PHYSICIANS OFFICES ONLY, NOT FOR DIRECT LAB USE

TO PARTICIPANT: Please use this form to obtain your lab and screening tests from your healthcare provider. Premier Community Health must receive values for the applicable test parameters listed on the back of this page in order to complete your Biometric Screening. Please complete the following contact information and follow the directions provided below. All programs are confidential and HIPAA-compliant. Any information shared with the Premier Community Health team will not be disclosed except in accordance with HIPAA laws. **ALL FIELDS BELOW ARE REQUIRED.**

Participant Name: _____

Participant Employer: _____PIQUA CITY SCHOOLS_____

DOB: _____ / _____ / _____ Medical Mutual Member ID Number: _____

Phone #: _____ Today's Date: _____ / _____ / _____

IMPORTANT NOTES

- You may submit blood/screening tests completed by your health care provider on or after **11/1/2018.**
- Results must be written on this form and your health care provider information must be completed below.
- This form must be completed and provided back to Premier Community Health no later than **10/31/2019** to receive credit.

TO LICENSED MEDICAL PROFESSIONAL: The health management program offered through Premier Community Health is not intended to treat, diagnose or replace physician involvement, but rather to create and promote an atmosphere of healthy living and learning through the implementation of wellness initiatives. For more information, please call Premier Community Health at 1-877-274-4543. ALL FIELDS BELOW ARE REQUIRED.

Licensed Medical Professional Name:

Phone #: _____

Address: _____

City: _____ State: _____

Licensed Medical Professional Signature: _____

License #: _____ Test Date: _____ / _____ / _____

TEST PARAMETER	VALUE	UNITS
Fasting	Yes	No
Total Cholesterol		mg/dL
HDL Cholesterol		mg/dL
Triglycerides		mg/dL
Blood Sugar		mg/dL
Systolic Blood Pressure (rest)		mmHg
Diastolic Blood Pressure (rest)		mmHg
Height		in
Weight		lbs
Waist Circumference		in
Hemoglobin A1C *(optional*)*		%
LDL Cholesterol *(optional*)*		mg/dL

You can submit your form one of three ways:

(1) By emailing to PCHInformation@premierhealth.com

(2) Via secure fax: (937) 641-7061

(3) Via mail to the address:

ATTN: Premier Community Health
BLDG A – 3RD FLOOR,
3170 Kettering Blvd, BLDG A
Dayton, OH 45439

**Value will not be used to determine incentives*