2018 City of Saint Paul Health Screening Form

Please use this form to submit your health screening numbers collected March 1, 2017 and February 28, 2018. All fields on this form are required. Your form will not be processed if information is missing. Please print clearly. **Please fax the completed form to HealthPartners at 952-883-6767 (confidential fax) by 11:59 p.m. CST on *February 28, 2018.*** Or email the form to info@journeywell.com. Forms received after this date will not be processed.

Participant Information *(please print)*

Name: _____

Participant date of birth: (MM/DD/YYYY) _____ **Phone number:** (with area code) _____

Participant email: _____ **If needed, may we leave a detailed phone message:**

Member ID: _____ **New Hire Date:**

Signature: _____ **Date:** _____

By signing this, you are authorizing your health care provider to give this information to HealthPartners. You are also authorizing HealthPartners to release minimum amount of information necessary such as program completion to this employer or their designated business associate, in order to administer the reward program. Your personal health information is not shared with this employer. Please note that this form is required for all health screenings not performed at the worksite.

Collection must be between March 1, 2017 and February 28, 2018

Screening Results (To be filled out by your doctor)

Collection Date: _____

Blood pressure: **Systolic:** _____

Diastolic: _____

Blood glucose: _____ ☐ **Fasting** ☐ **Non-Fasting**

Total cholesterol: _____ ☐ **Fasting** ☐ **Non-Fasting**

HDL: _____ **BMI:** _____

LDL: _____ **Height:** _____

Triglycerides: _____ **Weight:** _____

Doctor name: (please print) _____ **Doctor title:** (please print) _____

Doctor signature: _____ **Phone:** _____

*A signature is required on all submitted forms.

HealthPartners Internal Office Use Only

Date Received: _____

Date Processed: _____