2021

MD BIOMETRIC FORM - STEP 2

MEMBER NAME:	**EMPLOYER:**
ADDRESS:	**PHONE NUMBER:**
DATE OF BIRTH:	**EMAIL ADDRESS:**

Blood Work Fasting? Yes / No **Gender: __Male __Female** **Female-Currently Pregnant: ___ Yes ___No**

Health Measure:	Date	Results:	Exceptions:
Current Smoker Smoking Cessation Counseling		____YES ___ NO ____Completed ____Declined	
BMI Waist Circumference (optional)		Height =_____ Inches Weight=_____ Pounds _____ Inches	If pregnant use pre-pregnancy information
Blood Pressure		_____ mmHg	___ Taking blood pressure medication
Fasting Total Cholesterol HDL: LDL: Triglycerides:		_____mg/dl _____mg/dl _____mg/dl _____mg/dl **Ratio _____:_____**	
Glucose HbA1c (optional – physician's discretion)		Fasting Blood Sugar: _____mg/dl _____ %	___ Diagnosed Diabetic

HEALTH SCREENINGS	COUNSELING	IMMUNIZATIONS	COUNSELING
○ Prostate	__Yes __No __Declined	○ Flu	__Yes __No __Declined
○ Breast Cancer	__Yes __No __Declined	○ Pneumococcal Vaccine	__Yes __No __Declined
○ Cervical Cancer	__Yes __No __Declined	○ Pertussis Update	__Yes __No __Declined
○ Colorectal Cancer	__Yes __No __Declined	○ Shingles	__Yes __No __Declined
○ Skin Cancer	__Yes __No __Declined	○ HPV Vaccine	__Yes __No __Declined

Health Practitioner Signature or Office Stamp: _____ Date: _____

Health Practitioners Phone Number: _____

All information will be kept confidential within the Wellness Program and specific results of an individual will not be shared. Information will be included in the individuals Health Action Report provided at the completion of the Personal Health Profile. The submission of this completed form will be noted and that information used to towards the administration of incentive reward.

☐ **Permission to Release this completed form to the Wellness Office at Empire State Highway Contractors Assn, Inc. Please fax it to the attention of the Wellness Coordinator at 315-895-5307**

Members Signature: _____ Date: _____

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Steps:

1) Make your appointment to complete your Annual Physical Exam (include blood work).

   a. Give this form to your doctor for completion.
   b. Once complete: mail, email (good cell phone picture) or fax to:

Mail: Empire State Highway Contractors Association
Wellness Coordinator
2481 Higby Road
Frankfort, NY 13340

Fax: 315-895-5307

E-mail: pflaherty@eshca.org

2) This exam is covered by your ESHCA insurance once within the calendar year ($0 copay). **Be sure to take your medication list so you can re-evaluate your medications and dosages with your doctor.**

3) If you have already completed your exam for the current year, drop this form off to your doctor's office for completion. Either make-arrangements to pick it up or have them send it in on your behalf.

Follow the 3 Steps to Receive the $200 Incentive:

1) Submit the General Health Assessment (www.eshca.org or call/email me)
2) Submit MD Biometric Form
3) Submit MVP Explanation of Benefits (receipt from MVP) $200

Questions or comments contact:

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Fax: 315-895-5307
pflaherty@eshca.org

Website: www.eshca.org