Ozaukee County **Biometric Form**

Employee/Spouse

Employee/Spouse

Please fill out the top portion of this form and take it to your medical provider when you go for your health screening. Once completed by your provider, it is YOUR responsibility to submit this into the wellness portal.

Patient Name (Please Print)

Date of Birth

___ /___ /___

Patient Phone Number

Ozaukee County: Employee ___ Spouse ___

If the Patient Listed is a Spouse: Employee Name

Employee Date of Birth

___ /___ /___

Upload this form into the WellRight/Axum "MeasureUp" challenge.

Medical Provider

Medical Provider

Your patient has the opportunity to complete a biometric screening as part of a health plan incentive program. Please review the components to be included in the screening. When the screening is complete, please fill out this form, sign and date it, and return it to the patient. Please fill out this form completely; missing data will result in this form being rejected

ANNUAL HEALTH SCREENING CRITERIA	RESULTS
BLOOD PRESSURE < 130/90	______ / ______
WAIST CIRCUMFERENCE (Female: < 35") (Male < 40")	Female _______ Male _______
TRIGLYCERIDE (FASTING) < 150 mg/dl	TRIGLYCERIDE: ______
HDL CHOLESTEROL (Female: > 50) (Male: > 40) mg/dl	HDL: ______
BLOOD GLUCOSE (FASTING BLOOD SUGAR) < 100 mg/dl	Glucose: ______

Provider Signature

Provider Phone Number

Please Print (or Provider Stamp)

___ / ___ / ___

Date Tests Administered