



Physician Results Form for non-HAP members

Henry Ford Allegiance Health

Print Name _____ Date of Birth _____

Employees at Henry Ford Allegiance Health participating in Reward Your Health **who are not HAP members** must have a provider (or provider's office staff) complete this form and fax it *It's Your Life* at (517) 205-5941. This form, when submitted in full, meets the Know Your Numbers component of the program.

Blood pressure, height and weight measurements must be completed after **January 1, 2017** to qualify. Lab values must be completed after **January 1, 2015** to qualify.

<u>Resting Blood Pressure Measurement</u>		<u>Date of Service:</u>
Systolic _____ mmHg		
Diastolic _____ mmHg		
<u>Height and Weight Measurements (please indicate units)</u>		<u>Date of Service:</u>
Height (without shoes) _____ inches/meters		
Weight (without shoes) _____ lbs/kgs		
<u>Labs</u>		
Lipid panel and Glucose tests must be FASTING measurements.		
	Result (Value and Units)	Date of Service
Total Cholesterol		
HDL Cholesterol		
LDL Cholesterol		
Triglycerides		
Glucose OR HbA1c		

Please have your physician's office indicate the value and date of service below.

**Your physician's office may require you to sign a waiver releasing information to Henry Ford Allegiance Health Prevention & Community Health. All personal health information provided will remain confidential and secure.*

Provider or Office staff name: _____

Provider or Office staff signature: _____