GRIFFIN HEALTH

Biometrics Screening Form 2019-2020

Section I: Patient Information

First name ☐☐☐☐☐☐☐☐☐☐ Date of Birth ☐☐/☐☐/☐☐☐☐

Last name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ○ Male ○ Female

Phone Number ☐☐☐ – ☐☐☐ – ☐☐☐☐ Last Four SSN ☐☐☐☐

E-mail ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Section II: To Be Completed by MD or LIP

Date of Exam ☐☐/☐☐/☐☐☐☐

Lab Collection Date ☐☐/☐☐/☐☐☐☐

Fasting?: ○ Yes ○ No

Blood Pressure

Systolic	Diastolic	Glucose	A1C (Mandatory)	BMI	Total Cholesterol	HDL
☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐

Height in Inches	Weight in Pounds	Waist Circumference in Inches	Triglycerides	LDL
☐☐	☐☐☐	☐☐☐	☐☐☐	☐☐☐

Preventative Screenings - MD or LIP to determine if the following are medically necessary

	Yes Completed	No Not Completed	N/A Not Needed
Pap Smear (For Women) Within 3 years if 21 or older	○	○	○
Mammogram (For Women) Within 1-2 years if 40 or older	○	○	○
Prostate Cancer Screening (For Men) 45 or older with family history	○	○	○
Colorectal Screening (Adults over 50) Fecal Occult Blood Test or Colonoscopy	○	○	○

MD or LIP Phone Number ☐☐☐ – ☐☐☐ – ☐☐☐☐

☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

MD or LIP Name First Last

MD or LIP Signature Date

ALL INFORMATION IS REQUIRED Please review and submit completed form to:

Mail: Griffin Health Services, Attn: Population Health Department, 130 Division Street, Derby, CT 06418

Email: mywellness@griffinhealth.org (Subject: Griffin Employee Wellness)

Fax: 203-732-1342 / Attn: AgeLess Program