





## Health Risk Assessment Biometric Screening (Part One) Primary Care Provider Form

(NOTE: Lab results must be from July 1, 2009 – November 20, 2009.)

### SECTION I: TO BE COMPLETED BY MARQUETTE UNIVERSITY EMPLOYEE

PLEASE PRINT ALL INFORMATION

Marquette ID number:(9-digit #) \_\_\_\_\_ Insurance Type: (Please circle one): EPO PPO Other

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Section II: TO BE COMPLETED BY YOUR PRIMARY CARE PROVIDER

Test Date: \_\_\_\_\_ Fasting? YES NO

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_/\_\_\_\_\_

#### Blood Analysis:

Total Cholesterol: \_\_\_\_\_ HDL: \_\_\_\_\_ LDL: \_\_\_\_\_ Triglycerides: \_\_\_\_\_ Glucose: \_\_\_\_\_

Primary Care Provider's Printed Name: \_\_\_\_\_

Primary Care Provider's Signature: \_\_\_\_\_

Primary Care Provider's Address: \_\_\_\_\_

Primary Care Provider's Phone Number: \_\_\_\_\_

Comments: \_\_\_\_\_

**Please fax this information to:**

Total Health Dept  
Aurora Health Care  
Attn: Justin Plamann  
Phone: (262) 860-7951  
Fax: (262) 860-7940

**DO NOT SEND TO MARQUETTE UNIVERSITY**

