MARQUETTE UNIVERSITY

Be The Difference.

June 2017

Dear Primary Care Provider,

Your patient is an employee or spouse of an employee of Marquette University and is requesting your assistance. In an effort to maintain and improve health and wellness, Marquette University is offering a free Health Risk Assessment. The first part of the Health Risk Assessment is biometric testing. Your patient has indicated that they have had or will have the biometrics testing at your office between **July 1, 2017 and November 17, 2017.**

Please fax the results to: Aurora Wellness Services
Aurora Health Care – Attn: Joan Stigler
Fax: (414) 525-2570

Do not send the results to Marquette University. Please fax your patient's results no later than November 17, 2017. (*Please note, this form must be completed by the provider and can be faxed directly to Aurora by either the provider or the patient).*

In addition, please make a copy of this form for your patient. They may complete step two of the Health Risk Assessment process by filling out the online Health Risk Assessment (questionnaire) using the results of your biometrics exam.

Thank you in advance for your cooperation with Marquette University and its partner, Aurora Health Care. If you have any questions please feel free to contact, Aurora Health Care, Wellness Services at (877) 765-3213, Option # 1.

Aurora Health Care

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

(NOTE: Lab results must be from between July 1, 2017 and November 17, 2017.)

SECTION I: TO BE COMPLETED BY PATIENT

PLEASE PRINT ALL INFORMATION

Name of Marquette Employee_____ **9 Digit Employee Number**_____

Who are you: (check one)
☐ **Marquette Employee**
☐ **Spouse of a Marquette Employee**

First Name:_____ **Last Name**:_____ **Date of Birth**: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: ( )_____ **Work Phone** ( )_____

Email Address: _____

An email notification will be sent to patient once Aurora Wellness Services receives this completed form. Please print email clearly.

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: _____

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