

Must be submitted by October 2, 2020

Alternate Biometric Screening Form Forsyth County Government Wellness Program

To be completed by Wellness Program participant:

Participant Name: _____

Gender: _____ Date of Birth: ____ / ____ / ____

Address: _____

Telephone #: _____ Email: _____

Employee ID (Retirees): _____ Last 4 of SSN (Spouses): _____

To be completed by healthcare provider (all fields are required):

Date of Biometric Collection: ____ / ____ / ____

Height: ____ ft. ____ in. Weight: ____ lbs

Blood Pressure: ____ / ____

Waist circumference: _____

Date of Lab Draw: ____ / ____ / ____

Total Cholesterol: _____

HDL: _____ LDL: _____ Triglycerides: _____

Glucose: _____ A1C: _____

Fasting: **Fasting** or **Non-Fasting** (circle one)

Printed name of healthcare provider: _____

Signature of healthcare provider: _____

NPI: _____ Date / Time: _____

Once completed, please:

Fax this form Attention: Katherine Ivers to (336) 716-1635 or

Scan and email to fcgwellness@wakehealth.edu or

Mail to Katherine Ivers at Piedmont Plaza II, 2000 W 1st St, Suite 406, Winston-Salem, NC 27104