Cambridge Health Alliance and Harvard Pilgrim Health Care

Biometric Results Form

PARTICIPANT INSTRUCTIONS: Please complete the top part of this form and then have your doctor's office complete the lower half and return within 10 days. If you are not due for a doctor's visit, your doctor's office can complete this form with values from an earlier visit. Values submitted must be within the past 6 months.

PARTICIPANT INFORMATION		
_____ FIRST NAME	_____ LAST NAME	_____/_____/_____ TODAY'S DATE
_____/_____/_____ DATE OF BIRTH	GENDER: F / M (please circle one)	_____/_____/_____ PHONE NUMBER
NUMBER AND STREET ADDRESS: _____		CITY: _____
STATE:	ZIP:	
Employer: _____ Address: _____ _____		__ __ __ __ __ __ __ __ __ - __ __ Health Plans Inc. # (found on your member ID card) ____ ____ ____ ____ Last 4 digits of Social Security Number
By signing below, I give my doctor's office permission to e-mail or fax this form to the fax number listed below. Participant signature (Required): _____ Date: ____/ ____/ ____		

DOCTOR'S OFFICE INSTRUCTIONS: Please fill out completely with the most recent values for these measures. Please note that if some of these values are not clinically indicated for the patient, you can leave them blank. **Please fax form to: 617-509-4250 within 10 days.**

Date of visit/ test	Biometric measure	Results
	Height	in
	Weight	lbs
	Body Mass Index (BMI)	___ ___. ___
	Blood pressure	/ mmHg
	Total Cholesterol ☐ fasting ☐ non-fasting	mg/dL
	HDL Cholesterol ☐ fasting ☐ non-fasting	mg/dL
	Glucose (blood sugar) ☐ fasting ☐ non-fasting	mg/dL

Provider Information (required)	
Provider name / Practice name/Practice address (please print):	
Provider telephone #:	Date form completed: