Health and Wellness Program

Physician Lab Report Form
Palm Beach County Firefighters

To The Participant: See below regarding biometric testing.

Option 1. You may submit recently completed blood work by your health care provider.

- The testing needs to include all tests listed on the back of this form.
- The results need to be entered on this form and signed by your provider.
- Results must be received no later than 90 days after the lab draw

Option 2. You may go to your health care provider and have blood work completed.

- **The testing needs to have been completed after a fasting period (8 or more hours) and include all tests listed.**
- The results need to be entered on this form and signed by your provider.
- Results must be received no later than 90 days after the lab draw

PARTICIPANT Name: _____
PARTICIPANT Birth Date: _____
PARTICIPANT Phone Number: _____

I agree to the release of the laboratory test results requested below from the provider to UMR Care Management for the purpose of administering the Health and Wellness program. I understand that the Health and Wellness staff may contact me regarding my results, but that any additional participation on my part after this contact is purely voluntary. I understand that I have a right to revoke this authorization in writing to the provider at anytime, but the revocation will not apply to information that has already been released in response to this authorization.

PARTICPANT Signature: _____

To The Physician or Other Provider:

The Health and Wellness program is administered by UMR Care Management on behalf of the participant's or the participant spouse's employer. The program is designed to identify and reduce the risk for developing a chronic health condition in the future. The program is not intended to replace or provide medical advice. For information, call us at 1-800-207-7680.

Please provide the dates and results of laboratory tests completed for this participant as outlined below.

LAB TEST	RESULT	UNITS	TEST DATE
Height		In.	
Weight		Lbs.	
Waist Circumference		In.	
Total Cholesterol		mg/dL	
HDL Cholesterol		mg/dL	
LDL Cholesterol		mg/dL	
Triglycerides		mg/dL	
Fasting Blood Glucose		mg/dL	
Systolic Blood Pressure		mm Hg	
Diastolic Blood Pressure		mm Hg	

PROVIDER SIGNATURE: _____
PROVIDER NAME (Please print): _____
PROVIDER PHONE NUMBER: _____

CLINIC or LAB NAME: _____
CLINIC or LAB PHONE NUMBER: _____-

Fax this completed form to:

UMR
Attn: Health and Wellness Program
Fax: 866-681-0855

For questions please contact:

UMR
Health and Wellness Program
Phone: 800-207-7680