County of Monroe
The Florida Keys

Employee Health Preventive Care - Assessment Acknowledgment Form
Effective January 1, 2017
Services provided between: 11/1/16 through 10/31/17

Employee Name: _____ **Age:** _____
(Please Print)

Male:_____ Female:_____

EMPLOYER: _____
(Please Print)

Physician Name: _____**Completion Date:** _____
(Please Print)

Physician Acknowledgement: My signature below indicates that the following tests, assessments, clinicals indicated, pertain to the employee identified above, have been measured, if I deemed appropriate . The results of which have been reviewed with the employee in accordance with established treatment protocols.

Biometrics Information:

Check if completed		Recommended tests (Not required) if applicable at Physician's discretion:
	Wellness checkup/Physical	**Vitamin D**
	The below can be done at the County's annual health fair or with your personal physician:	**Vitamin B**
	Height/Weight	**CBC**
	Blood Pressure: Systolic/Diastolic	**CMP**
	Cholesterol : LDL/HDL/Triglycerides	**TSH**
	Blood Sugar Level	**Bilirubin screening**
	Body Mass Index (BMI)	**HBA1c (if diagnosed diabetic)**

Required Preventive Screenings discussed with Physician. If screening is recommended and done at a different office (such as a hospital), proof of procedure/visit with name of patient and date of procedure must be attached to this form.

_____**Mammogram**: Annually at ages 40+
OR
_____ Not required at this time (age, screening given within past year, etc.)

_____**Pap Test:** Women age 21-65 every 3 years or women age 30-65 Pap Test/HPV combined every 5 years; Ages 65+ discuss with doctor
OR
_____Not required at this time

_____**Screening for Colorectal Cancer**: Ages 50-75 with either a colonoscopy, fecal occult blood test or sigmoidoscopy
OR
_____Not required at this time

_____**Abdominal Aortic Aneurysm Check:** One-time men ages 65-75 who have ever smoked
OR
_____Not required at this time

_____**Lung Cancer Screening:** Ages 55-80; 30 pack smoker history, current smoker/quit within past 15 years
OR
_____Not required at this time

_____**Bone Mineral Density Screening and prescribed medication for osteoporosis:** Women beginning 65+ and in younger women who have increased risk
OR
_____Not required at this time

_____**Prostate Cancer Screening:** Discuss with doctor

_____**Skin Cancer Screening:** Discuss with doctor

Doctor:

I have given the patient the results of these tests and the employee has been counseled on the results and necessary follow up to prevent further health issues:

Physician Signature: _____Date: _____

Physician Address: _____

Physician Phone #: _____

Please give patient a copy of this form, completed by physician and mail completed, signed form to:
Monroe County Employee Benefits Office
Gato Building, 2nd Floor, Room 268
1100 Simonton Street
Key West, FL 33040

EMPLOYEE SIGN BELOW:

I hereby certify that I do not currently use tobacco products and agree to remain tobacco free while participating in the Wellness Program. Tobacco products are defined as cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, dip, electronic or e-cigarettes that contain nicotine or any other product that contains tobacco or nicotine. Nicotine replacement products such as gum and patches are also considered tobacco products.

I further understand that I may be subject to testing to verify non-use of tobacco products. A refusal to submit to a test is considered "positive" for tobacco use and I will not be eligible to participate in the Wellness Program.

_____	_____	_____
Employee Name	**Employee Signature**	**Date**

Submitted to County on: _____
Date
Received by Employee Services Employee Name/Signature: _____ Date: _____