INTERVENT HEALTH NUMBERS

IMPORTANT: It is your responsibility to ensure that all information on this form is complete.
Please fax this page only to our secure fax line at: INTERVENT, c/o Health Numbers
Fax: 912-349-2254
You may also upload this form to the "My Labs" section from your main dashboard.

To be completed by the patient (please print legibly):

Print Name:_____ Date of Birth:_____ Gender: M____ F____

Home Address: _____ City:_____ State: _____ Zip:_____

Telephone: (_____)_____-_____ Email: _____

Work Site Location:_____ Circle One: Employee Spouse

Personnel Number:_____ *Signature:*_____

"I acknowledge that I have read, understand and agree to the terms of the release of my personal health information and waiver as described on this form."

To be completed by the doctor/health care provider:
(All values should be provided, if available. Values with an asterisk are absolutely mandatory.)

HEALTH NUMBERS

Date collected:_____ (must be within 365 days of the health risk assessment)

Height* (inches):_____ Weight* (pounds):_____ Blood Pressure* (mmHg):_____/_____

Waist circumference (inches): _____ (taken at the natural waist above the hip bone in a horizontal plane)

Blood Values* (check one): ____Non-Fasting ___Fasting (at least 8 hours with no caloric intake)

Total Cholesterol* (mg/dL):_____ LDL Cholesterol (mg/dL):_____

HDL Cholesterol* (mg/dL):_____ Triglycerides (mg/dL):_____

Blood Glucose* (mg/dL):_____ *and/or* A1C (%):_____

Doctor's Name (Print):_____ Phone: (_____)_____-_____

Doctor's Address:_____

Doctor or Health Care Provider Signature:_____
Date:_____

If health numbers are provided by the patient, a copy of the original laboratory report or print-out from the electronic health record must be attached. Any form provided by the patient must clearly show patient's full name, date of birth and address.