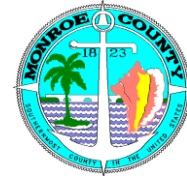


County of Monroe

The Florida Keys



Employee Health Preventive Care - Assessment Acknowledgment Form

Passport to Wellness Year 2021

Services provided between: 11/1/2020 through 10/31/21

Discount Period: 1/1/2022– 12/31/2022

Employee Name: _____ **Age:** _____

(Please Print)

Male: _____ **Female:** _____ **EMPLOYER:** _____ (Please Print)

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

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	Comprehensive Metabolic Panel (CPT Codes 80053, 84436, 84479)
	<i>The below can be done at the County's annual health fair or with your personal physician:</i>	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/Pelvic Exam: 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. _Date Last Completed: _____

____ Screening for Colorectal Cancer: Ages 50-75 with either a colonoscopy, fecal occult blood test or sigmoidoscopy

OR

____ Not required at this time Date Last Completed: _____

_____ **Abdominal Aortic Aneurysm Check:** One-time men ages 65-75 who have ever smoked or history of AAA
OR

_____ Not required at this time Date Last Completed: _____

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

_____ Not required at this time Date Last Completed: _____

_____ **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 Date Last Completed: _____

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

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

_____ **HIV and other Sexually Transmitted Infections (STIs):** 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.

_____ I hereby certify that I **currently use** tobacco products, and have **completed a qualified tobacco cessation program during the wellness program period and have attached a copy of documentation verifying my participation (certificate/letter).** 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.

NOTE: * Original assessment form completed by physician must be submitted to Monroe County Employee Benefits Office along with any proofs of age appropriate screenings. DO NOT email or fax.

***If COVID-19 safety measures are recommended, clear and legible email/fax submissions as above will be accepted.**

Employee Name

Employee Signature

Date

Submitted to County on: _____

Date

Received by Employee Services Employee Name/Signature: _____ **Date:** _____