

Auburn University Healthy Tigers- Provider Screening Form

Instructions: If you can not or choose not to participate in the Healthy Tigers screenings through the AUPCC, you may submit your health screening results through your physician. You are to complete **Section 1** of the form and your provider is to complete **Section 2**.

Certain lab tests associated with the Healthy Tigers Program when performed by your physician may only be covered once every 5 years by AUBCBS and you may be responsible for additional lab costs.

NAME (PLEASE PRINT): _____ SUBSCRIBER BANNER NUMBER: _____

AGE: _____ DATE OF BIRTH: _____ GENDER (CHECK ONE): MALE FEMALE

SUBSCRIBER NAME (AS APPEARS ON AU BCBS INSURANCE CARD): _____

AU BCBS CONTRACT NUMBER: _____

DAYTIME OR CAMPUS PHONE NUMBER: _____ E-MAIL ADDRESS: _____

What best describes your race/ethnicity?

White Black/African American Asian Indian or Alaska Native
Hispanic/Latino Native Hawaiian/Pacific Islander Other

Do you **HAVE** (or have you been told you had) any of the following? (Mark all that apply.)

High Cholesterol High Blood Pressure or Hypertension Diabetes

Do you take **MEDICATION** for any of the following? (Mark all that apply.) Optional: Please provide a list of all of your medications on the back of this form (including prescription, over the counter, vitamins, and minerals)

High Cholesterol High Blood Pressure or Hypertension Diabetes

SECTION 2 (To Be Completed by Healthcare Provider)

REQUIRED DATA

Blood Pressure _____ / _____ mmHg

Height _____ ft _____ in

Total Cholesterol _____ mg/dL

Weight _____ pounds

Blood Glucose _____

BMI _____

Alarm values: Total Cholesterol ≥ 250
Blood glucose ≥ 200
Blood pressure - Systolic ≥ 160 mm Hg
Diastolic ≥ 100 mm Hg
BMI ≥ 35

OPTIONAL DATA

HDL Cholesterol _____ mg/dL

TC/HDL Ratio _____

The above mentioned member has been evaluated in my office and counseled regarding his/her risk factors. In particular, I have noted any values that were above alarm values and responded as clinically indicated.

DATE TESTS PERFORMED BY PHYSICIAN (THIS DATE IS REQUIRED) _____

Healthcare Provider's Name: (Please Print) _____

Healthcare Provider Signature: _____

Healthcare Provider Address / Phone: _____

Please return completed form to:
AUBURN UNIVERSITY PHARMACEUTICAL CARE CENTER (AUPCC)

Attention: Healthy Tigers Program
2155 Walker Building, HSOP, 362 West Thach Avenue
Auburn University, Alabama 36849-5506

PHONE: (334) 844-4099 FAX: (334) 844-4019 E-MAIL: healthytigers@auburn.edu

For AUPCC use only: Banner EMR