RESET FORM

# 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:** _____ **SEX: (CHECK ONE):** ☐ **MALE** ☐ **FEMALE**

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

**AU BCBS CONTRACT NUMBER:**_____ **GROUP 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**

**Total Cholesterol**_____ **mg/dL**

**Blood Glucose** _____

**Height** _____**ft** _____**in**

**Weight** _____**pounds**

**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 ☐