County of Monroe

The Florida Keys

Employee Health Preventive Care - Assessment Acknowledgment Form
Passport to Wellness Year 2023
Services provided between: 11/1/2022 through 10/31/2023
Discount Period: 1/1/2024– 12/31/2024

Employee Name: _____ **Phone No.**_____ **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)**
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**: Women every two years between age 40-50. Annually at ages 50+
OR
_____Not required at this time (age, screening given within past year, etc.) Date last completed: _____

____**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 45-75 with either a colonoscopy, fecal occult blood test or sigmoidoscopy;
OR
once every 10 years.

____ 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 50-80; 20 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 for submission to Employee Benefits.
Physicians submitting forms on behalf of employee must also submit proof of age appropriate screenings to:
Monroe County Employee Benefits Department
1100 Simonton Street Suite 2-268 Key West, FL 33040
Email: wellness@monroecounty-fl.gov
Fax: 305-292-4452

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: * Either original, emailed and faxed assessment form completed by physician must be submitted to Monroe County with any proofs of age appropriate screenings.

_____ _____ _____

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

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

Approved BOCC 2/21/18