

* * * Communication Result Report (Nov. 18. 2022 9:14AM) * * *

1) AUM Warhawk Health Svcs.
2)

Date/Time: Nov. 18. 2022 9:13AM

File No. Mode	Destination	Pg(s)	Result	Page Not Sent
2516 Memory TX	918445605221	P. 1	OK	

Reason for error

E. 1) Hang up or line fail
E. 3) No answer
E. 5) Exceeded max. E-mail size

E. 2) Busy
E. 4) No facsimile connection
E. 6) Destination does not support IP-Fax



Physician Results Form

Completed form must be faxed to 844-560-8221.

Participant can also upload form to the Quest Wellness Screening Portal.

REQUIRED

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Company Name: ABBOTT LABORATORIES Contract Name: ABBOTT LABORATORIES 2022

You need to fill this section out: ☐ Complete this section before you see your healthcare provider.

Last Name: BARTON First Name: LINDSEY Sex: F

Self-identified gender: ☒ Female ☐ Male ID: 0DF8726C-F87B-5B3F-2B05-F70B2E40BE54

E-mail Address: LINDSEYBARTON@GMAIL.COM Phone Number: 3347147186

Address: 2026 RED HAWK ROAD

City: PRATVILLE State: AL Zip Code: 36067

By signing this requisition form and receiving these services, I acknowledge and agree to the Terms of Service which have been provided to me by Quest Diagnostics.

Participant Signature: [Signature] Date of Birth: 06/08/1982

Barcode: 8450 4386 2187 0190

This section must be completed by your Healthcare Provider: ☐ The information provided below will be kept confidential.

Date Test(s) Performed: 11/16/22 Testing and Measurements Must be Collected Between: 12/01/2021 11/30/2022

Height (in): 5 Height (cm): 127 Weight (lb): 140 Weight (kg): 63.5 BMI: 30.2

Trig (mg/dL): 78 HDL (mg/dL): 42 LDL (mg/dL): 181

Cholesterol (mg/dL): 77 Fasting (8-12 hours): ☒ Yes ☐ No

Waist Circumference (in): 31

Healthcare Provider Name: Robin Blackwell CRNP Signature: [Signature]

Healthcare Provider Address: Robin Blackwell CRNP

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B450 43D6 2187 0190



Physician Results Form

Completed form must be faxed to **844-560-5221**.

Participant can also upload form to the Quest Wellness Screening Portal.

REQUIREDALL FIELDS ARE REQUIRED unless otherwise noted with (*). Your form will be rejected if all fields are not completed. If you have not completed these tests with your Healthcare Provider, they will need to be completed before this form is submitted. Complete in **BLACK INK** for best results.

Company Name	ABBOTT LABORATORIES	Contract Name	ABBOTT LABORATORIES 2022
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You need to fill this section out.

! Complete this section before you see your healthcare provider.

Last Name	BARTON	First Name	LINDSEY	MI	T
Self Identified Gender	☒ Female ☐ Male	ADF8726C-FB7B-5B3F-2D05-F70B2E40BE54			
Email Address	LINDSEYTBARTON@GMAIL.COM			Phone Number	3347147186
Address	2026 RED HAWK ROAD				
City	PRATVILLE	State	AL	Zip Code	36067

By signing this requisition form and receiving these services, I acknowledge and agree to the Terms of Service which have been provided to me by Quest Diagnostics.

Participant Signature		Date of Birth	08/08/1982
FOR LAB USE ONLY	B450 43D6 2187 0190		

This section must be completed by your Healthcare Provider.

! The information provided below will be kept confidential.

Date Test(s) Performed	11.14.22	Testing and Measurements Must be Collected Between	12/01/2021	11/30/2022					
Height (feet)	5	Height (inches)	4	Weight (lbs)	140	Systolic BP	90	Diastolic BP	62
Trigs (mg/dL)	72	HDL	62	Total Chol	181	LDL	103		
Glucose (mg/dL)	77	Fasting >9 Hours	☒ Yes ☐ No						

Waist Circumference (inches)	31
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Healthcare Provider (Printed)	Robin Blackwell CRNP	UPIN/ NPI	1215274632
Healthcare Provider (Signature)	Robin Blackwell CRNP		