

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): EMILY SHIMAZ SUBSCRIBER BANNER NUMBER: 902145704

AGE: 29 DATE OF BIRTH: 9-28-88 GENDER (CHECK ONE): ☐ MALE ☒ FEMALE

SUBSCRIBER NAME (AS APPEARS ON AU BCBS INSURANCE CARD): EMILY M SHIMAZ

AU BCBS CONTRACT NUMBER: PPA848059183

DAYTIME OR CAMPUS PHONE NUMBER: 334-244-3892 E-MAIL ADDRESS: e.young2@auburn.edu

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 124 / 83 mmHg

Height 5 ft 3 in

Total Cholesterol 157 mg/dL

Weight 120.3 pounds

Blood Glucose 93

BMI 21.3

Alarm values: Total Cholesterol ≥ 250

Blood glucose ≥ 200

Blood pressure - Systolic ≥ 160 mm Hg

Diastolic ≥ 100 mm Hg

BMI ≥ 35

OPTIONAL DATA

HDL Cholesterol 42 mg/dL

TC/HDL Ratio 1.45

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) 12 / 11 / 2017

Healthcare Provider's Name: (Please Print) Carol Stewart, CRNP

Healthcare Provider Signature: Carol Stewart, CRNP

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 ☐