



Affix Lab I.D. Here

PERSONAL DATA AND CONSENT FORM

This questionnaire is a tool for assessing your current health. Only Health IQ Diagnostics, LLC and its authorized affiliates and service providers will have access to your individual information and results as needed to calculate your lifestyle score and create your personal report. Personal information is not shared with the sponsor employer or unauthorized parties.

(please print)

Name of sponsor employer _____

Is this your first Health Risk Assessment? Yes No

Name _____ (Last Name) (First Name) (MI)

Street Address _____

City _____ State _____ Zip _____

Your Social Security Number _____

Home phone number () _____

Work phone number () _____

Sex: Male Female

Date of birth: ____/____/____ (Mo/Day/Yr)

Age _____

Regarding your health plan, you are the: employee employee's spouse retiree retiree's spouse

If you are a spouse, what is the employee's name? _____

If you are a spouse, what is the employee's SSN? _____

If you are the employee, which shift do you work? 1st 2nd 3rd rotating

Please list your current medications: _____

Initial

I understand that a blood sample is to be withdrawn by Venipuncture and sent to the laboratory. The laboratory will analyze the blood sample for the tests checked [x]: [X] Cholesterol & its components [X] Blood chemistries [X] Nicotine

By signing this, I agree to the Participant release, consent and authorization terms on the reverse side of this form.

Signed: _____ Date _____

I do not want my final lifestyle score to be disclosed to the sponsor employer.

I do not want to receive informational materials and research data related to my health assessment.

The following is to be completed by an examiner at a health screening.

Company Code _____

My Personal Biometrics

- 1. Height without shoes to nearest 1/4" ____ft. ____in.
2. Fully clothed weight without shoes _____ pounds
3. MEN & WOMEN: Inches around neck, inferior to the larynx with tape sloping downward to the front, to nearest 1/4" _____ inches
4. WOMEN ONLY: Inches around waist measured horizontally at the level of minimal abdominal width, to nearest 1/4" _____ inches
5. WOMEN ONLY: Inches around hips measured horizontally at the largest hip circumference, to the nearest 1/4" _____ inches
6. MEN ONLY: Inches around abdomen measured horizontally at the level of the navel, to the nearest 1/4" _____ inches
7. Blood pressure _____ / _____ (repeat if above 140/90) _____ / _____
8. Blood sample? () Yes () No If yes, hrs fasted _____ If not, reason? _____

Name of Examiner _____ Date of Exam _____

I have reviewed the above measurements and acknowledge they have been recorded correctly.



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Event Verification Form

Complete this form ONLY if you have previously been in-service trained either on line or by a Wellness Project Coordinator. In-Service Trainings MUST be completed by every examiner.

Please fill in the blanks below:

EMSI Client Name: _____

Event Location: _____ Event Date(s): _____

Event Start Time: _____ Event Arrival Time: _____ Time/ Date Site was contacted: _____

Please check the box below to verify that you have read and understand each of these sections addressed in the event protocol

Understand and will comply with Dress Code

Knowledge of LDX Operation:
Configuration Menu
Trouble Shooting
Printer Set Up N/A
Finger-stick Procedures

Knowledge of Paperwork Completion
Knowledge of Paperwork Distribution

Knowledge of Post Event Procedures:
Shipment of Equipment/Extra Supplies
Biohazard Disposal
Site Clean Up

Blood Collection Supplies will be:
On-Site
Brought by Examiners

Have and will bring required examiner supplies

Special instructions for entering screening work site? Yes No
If YES, please list what those are: _____

By signing this form, you verify that you have been trained and understand the procedures and expectations set forth by this client and EMSI and will be responsible for your performance at the event.
Complete this form and fax it to Chantel Hutchins at 888-341-6721

Branch Name: _____

Examiner Name: _____
Please Print

Date: _____

Examiner Signature: _____

Employee ID #: _____