SEGIP Diabetes MTM Health Screening Form

Read and complete this form. Give the completed form to your MTM pharmacist to include in your record.

SECTION 1: PATIENT INFORMATION

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Insurance) ID#: _____

Navitus ID#: _____

Gender: _____male _____female Date of Birth: _____

SECTION 2: BIOMETRIC RESULTS

Date of screening (screening must occur within last 90 days)

Height: _____ Weight: _____ BMI: _____

Tobacco use with in last 6 months: ☐ Yes ☐ No

Daily aspirin: ☐ Yes ☐ No

Blood Glucose:

- Fasting: _____
- A1C: _____

Blood Pressure:

- Systolic: _____
- Diastolic: _____

Cholesterol:

- HDL: _____
- LDL: _____
- TRI: _____
- Total: _____

SECTION 3: PHYSICIAN INFORMATION

Clinic Name: _____ Physician's Name: _____

phone #: _____ Fax #: _____

Sharing My Personal Information

☐ **Consent for Release of Information**: I request my physician share information and medical records with my MTM pharmacist as necessary and appropriate to provide me with MTM service

☐ **Consent for Sharing Health Information:** My MTM Pharmacist may share my health information with others involved in treating me through the program. I may change or take back this consent for release of information at any time by notifying my pharmacist and physician in writing. Changes will not apply to information already released.

Participant's Signature: _____ Date: _____