OUTSIDE LABS FORM – 2022 LCC Incentive

Participant Instructions:

- **This completed form AND a copy of the lab results from your Primary Care Provider (PCP) must be faxed to St. Peter's Wellness at 447-2544. Official lab results MUST BE ATTACHED to this form.**
  - **Blood work submitted from an outside source must be dated no earlier than October 14, 2021 and no later than October 14, 2022.**
  - **Official office visit must be included for biometrics/vitals listed below or you may make an appointment to come to St. Peter's Wellness office for values. To make an appointment call 444-2128 or email wellness@sphealth.org.**
- **Online Health Questions and consent must be completed by calling 444-2128 or by visiting the following website: https://www.sphealth.org/community-health/health-and-wellness-screenings/lewis-and-clark-county-screenings**

Provider Instructions:

Your patient is participating in Lewis and Clark County Wellness Incentive that includes evaluation of blood screening results, along with biometrics and vitals. Please fill out all required info and attach the necessary information in the form of official medical documentation that includes labs and vitals/biometrics.

LABS/BIOMETRICS – ALL ARE REQUIRED*

***Blood panel** – Fasting Glucose and Total Cholesterol and/or Cholesterol Ratio
***Height, weight, waist circumference (measure at navel), and blood pressure –** Attach official medical office visit for these values. Handwritten values not accepted.

Screening Benchmarks	*Criteria*	*Reasonable Alternative Goals*
Cholesterol	Total less than or equal to 200 or Ratio ≤ 5 (m) ≤ 4.5 (w)	Reduce total by 10 or ratio by 0.5 or into criteria range
Fasting Glucose	Fasting glucose ≤ 110	Reduce by 10 points or into criteria range
Waist Circumference	Waist Circumference ≤ 40 (m) ≤35 (w)	Reduce waist size by 2" or into criteria range
Blood Pressure	Less or equal to 135/85 (measurements used individually)	Reduce value by 5 points or into criteria range
Tobacco/Nicotine Status	Tobacco/Nicotine Free for at least 3 months	Complete Montana Quit Line program and submit certificate

PATIENT INFORMATION

***Patient's Last Name:** _____ ***Patient's First Name:** _____ ***Gender:** _____

***Patient's Phone #:** ( ) - ***Patient's DOB:** / / ***Date of Visit:** / /

***Patients Email:** _____

SIGNATURES

Provider's Signature: _____ **Provider's Office Phone #:** _____