



Bricklayers Local #2 NY Health Fund Patient Biometric Screening Results

2021

Section I: Patient Information

First Name Date of Birth

Last Name Male Female

Phone Number Last Four SSN

Email

Section II: To Be Completed By Physician - Exam Labs must be completed between 1/1/2021 to 12/31/2021

Date of Exam

Date of Lab Collection Fasting Yes No

Blood Pressure

Height in Inches Weight in Pounds Systolic Diastolic Glucose

Total Cholesterol HDL Triglycerides LDL Cholesterol Ratio A1C if indicated

Preventative Screenings - Required if over age 26 - Physician to determine if the following are medically necessary.

	Completed	Not Completed	Not Needed
Pap Smear (for women) within 3 years if 21 or older	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mammogram (for women) within 1-2 years if 40 or older	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate Cancer Screening (for men) 45 or older with family history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colorectal Screening (adults over 50) Fecal Occult Blood Test or Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Electrocardiogram (EKG)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Stimulating Hormone (TSH)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Physician's Name (First and Last) Physician's Phone Number

Physician's or LIP Signature

Date

ALL INFORMATION IS REQUIRED. Please review and submit completed form to:

Mail: BAC Local #2NY Health Fund 300 Centre Drive Albany New York 12203

Fax: 518.456.4431



Congratulations on completing your exam and Biometric Screening!

Patients Name: _____ DOB _____ SS last 4 _____

Are you the (circle): Member Spouse Dependent

Members Name: _____ DOB _____ SS last 4 _____

Address: _____

Phone: _____

Results of your exam are confidential and will only be utilized for
BAC #2 health & wellness programs

To be eligible for the \$100 gift-card, you must have your physician complete the checklist (on the reverse side) and be eligible (insured or opt-out) with the Local #2NY Health Fund. Opt-out & single plan members will receive one card; 2-person plan members can receive 2 gift cards and family plan members can receive a \$100 gift card for spouse and ALL dependents ages 18-26.

If you have had a physical in the past year you may supply those results to the Fund Office and be eligible for the \$100 gift card. Call the office for more details 1-800-664-8314.

What gift card would you prefer (circle one):

Curtis Lumber Home Depot Dick's Sporting Goods Bass Pro Shops AutoZone

Best Buy Kohl's J.C. Penney Bed, Bath & Beyond TJ Maxx Macy's

Please return this form to:

BAC Local #2NY Health Fund
300 Centre Drive
Albany, NY 12203

Fax: 518-456-4431 (please fax both sides)

E-mail: cfarnan@baclocal2ny.com (please send both sides)