County of Monroe
The Florida Keys

Employee Health Preventive Care - Assessment Acknowledgment Form
Passport to Wellness Year 2025
Services provided between: 11/1/2024 through 10/31/2025
Discount Period: 1/1/2026– 12/31/2026

Employee Name: _____ **Phone No**. _____ **Age:** _____
(Please Print)

Male: _____ **Female:** _____   **EMPLOYER**: _____ (Please Print)

Physician Name: _____ (Please Print) **Completion Date:** _____

Physician Acknowledgement: My signature below indicates that the following tests, assessments, clinicals indicated, pertain to the employee identified above, have been measured, if I deemed appropriate. The results of which have been reviewed with the employee in accordance with established treatment protocols.

Biometrics Information:

Check if completed		Recommended tests (Not required) if applicable at Physician's discretion:
	Wellness checkup/Physical	Comprehensive Metabolic Panel (CPT Codes 80053, 84436, 84479)
The below can be done at the County's annual health fair or with your personal physician:		Vitamin B
	Height/Weight	CBC
	Blood Pressure: Systolic/Diastolic	CMP
	Cholesterol: LDL/HDL/Triglycerides	TSH
	Blood Sugar Level	Bilirubin screening
	Body Mass Index (BMI)	HBA1c (if diagnosed diabetic)

Required Preventive Screenings discussed with Physician. If screening is recommended and done at a different office (such as a hospital), proof of procedure/visit with name of patient and date of procedure must be attached to this form.

_____**Mammogram**: Women every two years between age 40-50. Annually at ages 50+
OR
_____Not required at this time (age, screening given within past year, etc.) Date last completed: _____

_____**Pap Test/Pelvic Exam:** Women age 21-65 every 3 years or women age 30-65 Pap Test/HPV combined every 5 years; Ages 65+ discuss with doctor
OR
_____Not required at this time. Date Last Completed: _____

_____**Screening for Colorectal Cancer**: Ages 45-75 with either a colonoscopy, fecal occult blood test or sigmoidoscopy; OR once every 10 years.

_____ Not required at this time   Date Last Completed: _____

Approved BOCC 2/21/18

_____**Abdominal Aortic Aneurysm Check:** One-time men ages 65-75 who have ever smoked or history of AAA
OR
_____Not required at this time.   Date last completed: _____

_____**Lung Cancer Screening:** Ages 50-80; 20 pack smoker history, current smoker/quit within past 15 years
OR
_____Not required at this time.   Date last completed: _____

_____**Bone Mineral Density Screening and prescribed medication for osteoporosis:** Women beginning 65+ and in younger women who have increased risk.
OR
_____Not required at this time.   Date last completed: _____

_____**Prostate Cancer Screening:** Discuss with doctor.
_____**Skin Cancer Screening:** Discuss with doctor.
_____**HIV and other Sexually Transmitted Infections (STIs):** Discuss with Doctor.

Doctor:
I have given the patient the results of these tests and the employee has been counseled on the results and necessary follow up to prevent further health issues:

Physician Signature:_____**Date:** _____

Physician Address: _____

Physician Phone #: _____

Please give patient a copy of this form for submission to Employee Benefits.
Physicians submitting forms on behalf of employee must also submit proof of age-appropriate screenings to:
Monroe County Employee Benefits Department
1100 Simonton Street Suite 2-268 Key West, FL 33040
Email: wellness@monroecounty-fl.gov
Fax: 305-292-4452

EMPLOYEE SIGN BELOW:

_____I hereby certify that I <u>do not</u> currently use tobacco products and agree to remain tobacco free while participating in the Wellness Program. Tobacco products are defined as cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, dip, electronic or e-cigarettes that contain nicotine or any other product that contains tobacco or nicotine. Nicotine replacement products such as gum and patches are also considered tobacco products. I further understand that I may be subject to testing to verify non-use of tobacco products. A refusal to submit to a test is considered "positive" for tobacco use.

_____I hereby certify that I **<u>currently use</u>** tobacco products and have completed a qualified tobacco cessation program during the wellness program period and have attached a copy of documentation verifying my participation (certificate/letter). Tobacco products are defined as cigarettes, cigars, pipe tobacco, chewing tobacco, snuff, dip, electronic or e-cigarettes that contain nicotine or any other product that contains tobacco or nicotine.

NOTE: * Either original, emailed and faxed assessment form completed by physician must be submitted to Monroe County with any proofs of age-appropriate screenings.

_____   _____   _____
Employee Name   **Employee Signature**   **Date**

Submitted to County on:_____
                                          Date
Received by Employee Services Employee Name/Signature:_____**Date:**_____