



Bricklayers Local #2 NY Health Fund Patient Biometric Screening Results

2023

Section I: Patient Information

First Name Date of Birth

Last Name Male Female

Phone Number Last Four SSN

Email MVP ID #

Section II: To Be Completed By Physician - Exam Labs must be completed between 1/1/2023 to 12/31/2023

Date of Exam Fasting Yes No

Date of Lab Collection

Blood Pressure

Height in Inches <input type="text"/>	Weight in Pounds <input type="text"/>	Systolic <input type="text"/>	Diastolic <input type="text"/>	Glucose <input type="text"/>
Total Cholesterol <input type="text"/>	HDL <input type="text"/>	Triglycerides <input type="text"/>	LDL <input type="text"/>	Cholesterol Ratio <input type="text"/>
				A1C if indicated <input type="text"/>

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 (over age 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) <input type="text"/>	Physician's Phone Number <input type="text"/>		

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!

Patient 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: mdoughtie@baclocal2ny.com (please send both sides)