IMPORTANT: If the form is not filled out or printed correctly, there will be a delay in the processing of your results. There will also be a delay if you include any additional pages other than the form on the following page.

*Please allow 72 hours for your health screening results to be reflected in your account.

**PRINTING INSTRUCTIONS**

<table>
<thead>
<tr>
<th><strong>DO</strong></th>
<th><strong>DON'T</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bring the original form to the doctor's office.</td>
<td>DO NOT FAX A COPY OF THE FORM TO YOUR DOCTOR. Your form will not be processed correctly.</td>
</tr>
<tr>
<td>Print form on an 8.5” x 11” paper.</td>
<td>DO NOT SHRINK OR SCALE YOUR FORM IN ANY WAY WHEN PRINTING. Your form will not be processed correctly.</td>
</tr>
</tbody>
</table>

**FORM SUBMISSION INSTRUCTIONS**

**FAX ONLY PAGE 2 TO ADURO AT (866) 877-7095**

Complete ALL fields, boxes and bubbles on the form.

In the clinical measurement section, enter a zero for any blank boxes (see example to the right).

The fax line is a HIPAA secure line, therefore a coversheet is not needed.

- Diastolic 080
- Diastolic 180

DO NOT FAX A COVER LETTER WITH YOUR RESULTS PAGE.

Forms other than the result sheet will not be recognized by our system and will slow processing of your results.
Health Provider Screening Form

COMPLETION DIRECTIONS
1. Please read the instructions and complete ALL fields like this:
2. You must have your doctor or doctor’s office complete and sign this form.
3. Fax the form to: (866) 877-7095
4. It is your responsibility to make sure this form is submitted.

First Name

Last Name

Gender:  □  Male  □  Female

By signing this form, I certify the following: I have truthfully checked the Agree or Disagree box that accurately reflects my use of tobacco/nicotine and I understand that tobacco products include cigarettes, cigars, chewing or pipe tobacco, nicotine gum or any other tobacco or nicotine products regardless of the frequency or method of use.

Signature ____________________________  Print Name ____________________________

Date ____________________________  Phone # ____________________________

EMPLOYEE

I hereby certify that I have not used any cigarettes, cigars, pipes, snuff, chewing tobacco, nicotine gum or other tobacco or nicotine delivery system in the last 6 months (mark one below).

□  Agree  □  Disagree

*** FOR PHYSICIAN OR OFFICE STAFF USE ONLY BELOW THIS LINE ***

Height FT IN

Weight LBS

Waist IN

Date Tested M M D D Y Y Y Y

Body Measurements

Blood Pressure

Systolic

Diastolic

HDL Cholesterol (mg/dL)

Total Cholesterol (mg/dL)

LDL Cholesterol (mg/dL)

Triglycerides (mg/dL)

Glucose (mg/dL)

Facility Name ____________________________

Certifying Agent Name ____________________________

NPI # ____________________________

Date ____________________________

□  REQUIRED: I certify these values are correct

Agent Signature ____________________________  Phone # ____________________________