Immediate Referral Form - Physician Contact Commitment

NAME	
PHONE	EMAIL

Test:	Glucose (Fasting)	Glucose (Non-Fasting)	Blood Pressure (Systolic)	Blood Pressure (Diastolic)
Your Result:	mg/dL	mg/dL	mmHg	mmHg
Threshold:	130 mg/dL or higher ☐	Over 200 mg/dL ☐	160 mmHg or higher ☐	100 mmHg or higher ☐

I acknowledge that my screening test results are out-of-range as indicated above. I commit to seeking immediate medical care from my personal healthcare provider, urgent care clinic, or occupational healthcare provider at my worksite for these abnormal results.

I understand that this screening service is offered for my benefit and information. The screening tests are not meant to replace the care of my personal physician. I also understand that screening tests can give false, positive, or negative results for a variety of reasons. I acknowledge that my physician is best able to interpret the results of these tests based on his/her understanding of my medical history.

I have read and agree with all the terms and conditions listed above.

Signature ***Date***

FOR SCREENING STAFF USE ONLY

Screener Name - Printed	Screener Signature	Date

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