Physician Wellness Screening

Results Form

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Dear Participant,

Your employer has offered you the opportunity to participate in their wellness program. You have been pre-approved to participate in a screening through your physician. Please complete the following steps to ensure your results are received in a timely manner.

1. Make a physical appointment with your Primary Care Physician to ensure there is enough time for you to be seen and your lab work processed and returned. Refer to your employer's communications for the screening window. If you do not have a Primary Care Physician, contact your benefits administrator for more information.

2. Keep your scheduled appointment for a physical only. Do not include a visit for your physical with other visits, like being sick for example. Make sure that you complete the participant sections of the "Physician Wellness Screening Results Form" prior to your doctor's visit.

3. Remember to fast 12 hours prior to your appointment. Nothing to eat or drink except water. Take medication as prescribed, and if you are unable to fast due to a medical condition, please follow your doctor's orders.

4. Take the "Physician Wellness Screening Results Form" to your appointment. Ask your physician to fill out the "Biometric Screening Results" section of the form with your physical results. Don't forget to fill out the rest of the form yourself.

5. Remind your physician that this information is time sensitive. Physician signature must be present to process results.

6. Submit the "Physician Wellness Screening Results Form" to your employer's wellbeing portal.

7. Results are typically available within 10 business days.

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Physician Form

Participant Information *(Completed by patient - please print)*

LAST NAME: **MIDDLE INITIAL:**

SEX: ☐ Male ☐ Female ☐ Other ☐ Prefer not to answer

FIRST NAME:

PHONE NUMBER: - - **BIRTH DATE:** / /

STREET ADDRESS:

CITY: **STATE:** **ZIP CODE:**

EMPLOYER NAME:

EMAIL:

PARTICIPANT'S SIGNATURE (REQUIRED): **DATE:**

PARTICIPANT'S NAME (PLEASE PRINT):

Biometric Screening Results *(Completed by physician)*

EXAMINATION DATE: / /

HEIGHT:

FT. IN.

BLOOD PRESSURE mmHg:

/

WEIGHT (LBS)**:**

BODY FAT %:

TOTAL CHOLESTEROL:

WAIST CIRCUMFERENCE (INCHES)**:**

A1C:

N/A

TRIGLYCERIDES:

LDL:

BMI:

COTININE:

N/A

HDL:

FASTING GLUCOSE:

PROVIDER'S SIGNATURE (REQUIRED): **DATE:**

PROVIDER'S NAME (PLEASE PRINT):