

Physician Wellness Screening Results Form

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.

Physician Form

Participant Information (Completed by patient - please print)

LAST NAME: _____ MIDDLE INITIAL: _____

FIRST NAME: _____ SEX: Male Female Other
 Prefer not to answer

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:	BLOOD PRESSURE mmHg:		
FT. IN.	/		
WEIGHT (LBS):	BODY FAT %:	TOTAL CHOLESTEROL:	
_____	_____	_____	
WAIST CIRCUMFERENCE (INCHES):	A1C:	TRIGLYCERIDES:	LDL:
_____	_____	_____	_____
BMI:	COTININE:	HDL:	FASTING GLUCOSE:
_____	N/A	_____	_____

PHYSICIAN'S SIGNATURE (REQUIRED): _____ DATE: _____

PHYSICIAN'S NAME (PLEASE PRINT): _____

