



PHYSICIAN WELLNESS SCREENING RESULTS FORM

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PARTICIPANT INFORMATION (COMPLETED BY PATIENT - PLEASE PRINT)

EMPLOYER NAME, LOCATION CODE, LAST 4 SSN, PHONE NUMBER, EMPLOYEE (P) / SPOUSE (D), PREGNANT, LEGAL LAST NAME, LEGAL FIRST NAME, SEX, DATE OF BIRTH, EMAIL ADDRESS, ADDRESS, CITY, STATE, ZIP

PARTICIPANT SIGNATURE: _____ DATE: _____

RELEASE OF HEALTH INFORMATION: By submitting this form, I am requesting my physician to report my biometric and laboratory results to HealthCheck360 to be included as part of an employer sponsored wellness program.

REQUIRED TO PROCESS RESULTS

HEIGHT (INCHES), WEIGHT (LBS.), WAIST (INCHES), BLOOD PRESSURE, BLOOD PRESSURE (IF 1ST > 120/80), LAB DATE, GLUCOSE, TRIGLYCERIDES, TOTAL CHOLESTEROL, HDL, LDL, EXAMINATION DATE, DOES PATIENT SMOKE, USE TOBACCO PRODUCTS OR NICOTINE SUBSTITUTES?, FASTING 8+ HR?

PHYSICIAN INFORMATION

Your patient is a participant in a health and wellness program sponsored program through their employer or spouse's employer. Through this wellness program, your patient has an opportunity to improve their health risks as they exhibit healthy lifestyle choices.

PHYSICIAN CLINIC, PHONE NUMBER

PHYSICIAN'S SIGNATURE: _____

PHYSICIAN'S NAME (PLEASE PRINT): _____

Email: Support@HealthCheck360.com | Phone: 866-511-0360 | Fax: 563-587-5720

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