HealthCheck360

PHYSICIAN WELLNESS SCREENING

New Castle County wellness program provides the opportunity to participate in a wellness screening through your physician. Please complete the following steps to ensure your screening results are received and approved by 09/22/26.

How do I schedule?

- Contact your Healthcare Provider and schedule an annual wellness appointment
- Visits/lab work from 10/01/2025 to 09/22/2026 will be accepted

What should I bring to my appointment?

- Download the **Physician Screening Form** your myHC360+ account
  - Complete the **Participant** section before your appointment
  - Reminder: Your doctor will need to return the completed form to you for upload.
- Healthcare Provider instructions (included on the next page)

How should I prepare for my screening?

- Fast 8-12 hours before your appointment
  - Speak with your physician if you have concerns about fasting
- Drink plenty of water
- Continue taking any prescribed medications
- Avoid strenuous activity

How do I submit my Physician Wellness Screening Form?

- Log in to your myHC360+ app
- Go to the **Health** tab at the bottom of your screen
- Scroll down and select **Physician Form** under the Biometric Screening section
- Select **Next**
- Fill in all required fields and upload a copy of your form
  - Phone must be in this format +15555555555
- Once submitted, you will receive a notification that results are under review
- Employees and spouses must complete separate forms and submit them through their separate myHC360+ accounts

When can I review my results?

- Your results are available within 7-10 business days after they are received on myHC360+. If your results are not available within 10 business days, please confirm that all required fields were included.

If you have any questions about your results or next steps, contact HealthCheck360 at 1-866-511-0360 ext. 5099 or support@HealthCheck360.com

PLEASE PROVIDE YOUR PHYSICIAN THE FOLLOWING INSTRUCTIONS:

ATTENTION HEALTH CARE PROVIDER:

Your patient is a participant in a health and wellness program sponsored through their employer.

Please return the attached "Physician Wellness Screening" form to your patient as soon as results are processed.

PLEASE COMPLETE THE FOLLOWING:

- Ensure the patient has completed and **signed** the participant section on the results form.
- Collect the biometric measurements, blood specimen and complete the remaining sections of the results consent form by following the instructions below.
- If a spouse form is being completed at the same time, please keep the forms separate. We are unable to process multiple forms together.
- Please ensure all required tests are coded as preventative, not diagnostic.
- If patient is enrolled in HealthCheck360's myCare360 program, please order the appropriate tests based on condition
    - Hypertension: Creatinine
    - Diabetes: Creatinine, A1C & Urine Microalbumin
    - Diuretic Medication: Potassium
- Submit invoices to the address on the patient's Health Insurance Card.
- **Return the completed form to your patient.**

PLEASE USE THE GUIDELINES BELOW WHEN COLLECTING MEASUREMENTS:

- **Height**: Perform the height measurement using a sliding height measuring stick. Have the patient remove their shoes and record to the nearest ¼ inch. Self-reported heights are not acceptable.
- **Weight:** Perform a weight measurement using a professional grade scale with a minimum capacity of 400 pounds. Have the patient remove their shoes and record. Do not make any adjustments for clothes.
- **Waist:** Use a soft tape measure. For waist measurement, place the tape measure at the navel. Record to the nearest ¼ inch.
- **Blood Pressure:** Perform using a standard sphygmomanometer, cuff size as appropriate. If the initial reading exceeds 120/80, retake on opposite arm and document result in 2nd blood pressure field.

HealthCheck360 Contact Information:
Support@HealthCheck360.com | Phone: 866-511-0360 ext. 5099

HealthCheck360

PHYSICIAN WELLNESS SCREENING RESULTS FORM

Upload to your my.hc360.app account by: 09/22/26

Only lab results from 10/01/25 to 09/22/26 will be accepted.

PHYSICIAN: PLEASE RETURN TO PARTICIPANT ONCE COMPLETE

PARTICIPANT INFORMATION (COMPLETED BY PATIENT – PLEASE PRINT)

EMPLOYER NAME: NEWCASTLECOUNTY`

COMPANY CODE: NEWCC

UNIQUE ID:

PHONE NUMBER: ___-___-____

EMPLOYEE (P) / SPOUSE (D): ☐ P ☐ D

PREGNANT: ☐ Y ☐ N

LEGAL LAST NAME:

LEGAL FIRST NAME:

SEX: ☐ M ☐ F

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. By signing above, I authorize the release of my personal health information and preventive health screening results listed on this form by my health care provider. This authorization shall remain in force for 12 months following the date of my signature below and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification. I understand that all fields must be completed in order for my form to be accepted.

REQUIRED TO PROCESS RESULTS

HEIGHT (INCHES): ☐☐

WEIGHT (LBS.): ☐☐☐

WAIST (INCHES): ☐☐

BLOOD PRESSURE: ☐☐☐/☐☐☐

BLOOD PRESSURE (IF 1ST > 120/80): ☐☐☐/☐☐☐

LAB DATE: __/__/__

TOTAL CHOLESTEROL: ☐☐☐

HDL: ☐☐☐

LDL: ☐☐☐

TRIGLYCERIDES: ☐☐☐

GLUCOSE: ☐☐☐

EXAMINATION DATE: __/__/__

DOES PATIENT SMOKE, USE TOBACCO PRODUCTS OR NICOTINE SUBSTITUTES? ☐ Y ☐ N

ADDITIONAL LABS- HYPTERTENSION: CREATININE. DIABETES: CREATININE, A1C, & URINE MICROALBUMIN. DIURETIC MEDICATION: POTASSIUM

CREATININE: ☐☐☐

A1C: ☐☐☐

POTASSIUM: ☐☐☐

URINE MICROALBUMIN: ☐☐☐

PHYSICIAN INFORMATION

Your patient is a participant in a health and wellness program sponsored 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. This program is not intended to treat, diagnose or replace physician involvement, but rather to create and promote an atmosphere of healthy living and learning.

PHYSICIAN CLINIC:

PHONE NUMBER: ___-___-____

PHYSICIAN'S SIGNATURE: _____

PHYSICIAN'S NAME (PLEASE PRINT): _____