Indiana University Health

2018 PHYSICIAN OPTION FORM

The patient's physician or medical provider must fax this completed form to Wayne Wellness at 317.536.4006

Please have your provider complete this physical form and report the values of blood draw (blood pressure, height, weight, waist size/ circumference, fasting glucose, A1C and Lipid Panel [Total Cholesterol, LDL Cholesterol, HDL Cholesterol and Triglycerides]). Only physicals that have been completed from July 1st, 2018 - June 30th, 2019 will be eligible to count towards the 2018 Biometric Screening.

** The patient will receive an email from Wayne Wellness confirming the receipt of this form within one week of submission. Should the patient not receive a confirmation it is the patients responsibililty to contact the clinic at 317.536.2200, and then follow up with their physician.*

PARTICIPANT COMPLETE THIS SECTION ONLY

Last Name (Printed) ____________ First Name (Printed) ____________ MI ____ Date of Birth (mm/dd/yyyy) ____/____/______

Address: ______________________________ Phone Number: ____________

Email: ______________________________ Gender: ☐ Male ☐Female

Employer: ______________________________ Last 4 digt SSN: ____________

Pregnant or Post-Partum (up to one year)

☐ Pregnant ☐ Post-Partum Delivery Date: ____/____/______

THIS SECTION TO BE COMPLETED BY MEDICAL PROVIDER PERFORMING PHYSICAL

Date of Physical ____/____/______

Blood Pressure: ________ Height (inches): ________ Weight (lbs.): ________

Waist Size/Circumference: ________ Fasting Glucose: ________ Total Cholesterol: ________

A1C: ________ Triglycerides: ________ HDL Cholesterol: _______ LDL Cholesterol: ________

Fasting: ☐Yes ☐ No Smoke: ☐Yes ☐ No

(Optional) Physician Notes:

Provider's Signature: ______________________________

Date: ____/____/______ Provider's Name (Printed): ______________________________

Phone Number: ____________

Consent information: This information, along with any personal health information provided in completing the Health Assessment, is maintained in a secure area within IU Health to be used only for calculating this incentive. It is not shared with your employer. IU Health will provide your employer aggregate information as part of a group summary report (individual data results will not be disclosed.) IU Health uses some of its subsidiaries, affiliates, and other agents to carry out the work of its wellness program.

To the extent it is necessary, I hereby consent to such release for these agents, employees and/or clinical providers of IU Health to have access to my health screening information in order to carry out their duties. **By submitting this form, I hereby consent to use of my biometric screening information for the purposes specified above, and grant any wellness program associate permission to contact me regarding my results.**

FOR OFFICE USE ONLY

Date Fax Received: ____/____/______ Date Entered: ____/____/______ Confirmation Email sent by: ______ Date: ____/____/______