Dear Participant,

Your employer has offered you the opportunity to participate via your physician in their wellness program. Please complete the following steps to ensure your results are received in a timely manner.

1. **Make an appointment with your Primary Care Physician** to ensure there is enough time for you to be seen and your lab work processed and returned by **September 30, 2018.**
2. **Keep your scheduled appointment for a physical only.** Make sure that you complete the participant sections of the "Wellness Screening Results Form" prior to your doctor's visit. Do not complete any more of the form at this time.

   Member ID and Group ID: Sections can be left blank
3. **Remember to fast 9 hours prior to your appointment.**
4. **Take the "Physician Wellness Results Form" to your appointment.** Provide your physician with instructions on the back of this form.
5. **Remind your physician that this information is time sensitive**.

If you have any questions, please contact your employer's Human Resource Representative or Benefits Administrator.

Please provide your physician with the instructions on the back of this form

ATTENTION HEALTH CARE PROVIDER:

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

Please complete the following:

1. Ensure the patient has completed and signed the participant section on the enclosed results form.

2. Collect the biometric measurements (below), blood specimen and complete the remaining sections of the results consent form.

3. **Fax the completed form to 1-855-827-6307** and provide a copy of the results form to the participant.

4. Make sure services are properly coded as preventative, not diagnostic.

Please collect the following biometric measurements:

- Height
- Weight
- Waist
- BMI
- Blood Pressure
- Pulse
- Triglycerides
- Total Cholesterol
- LDL
- HDL
- Glucose

Physician Wellness Screening Results Form

Participant Information (completed by patient - Please Print)

LAST NAME

MEMBER ID

FIRST NAME

MIDDLE INITIAL

GROUP ID

PHONE NUMBER

GENDER ○ M ○ F

BIRTH DATE

ADDRESS

CITY

STATE

ZIP

EMPLOYER NAME: Drake University

SPONSOR NAME: Wellmark

Release of Health Information:

By submitting this form I am requesting my physician to report my biometric and laboratory results to Hooper Holmes Health & Wellness to be included as part of my employer sponsored wellness program. By signing below, 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 for 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.

Signature: _____ Date: _____

Physician Information

PCP Office: Fax completed form to Hooper Holmes at 1-855-827-6307

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

Please complete this section for the above patient (please print).

PHYSICIAN NAME/CLINIC

PHONE NUMBER

CONTACT NAME

ADDRESS

CITY

STATE

ZIP

Biometric Screening Results (completed by physician)

EXAMINATION DATE

HEIGHT FT. IN.

BLOOD PRESSURE mmHg

HOURS FASTED

TRIGLYCERIDES

WEIGHT LBS.

PULSE

TOTAL CHOLESTEROL

LDL

WAIST (IN.)

BMI

HDL

GLUCOSE

Physician's Signature: _____ Date: _____

Physician's Name (please print): _____