



PHYSICIAN SCREENING FORM

Dear Doctor:

Your patient is participating in a wellness initiative through his or her employer. Part of this initiative involves obtaining a routine exam and simple biometric screening and sharing the results with Be Well Solutions. The patient's health information is *not* shared with his or her employer and we respect all elements of confidentiality.

If you have any questions about the screening process or wish to discuss any elements of the program, we invite you to call Be Well Solutions at (216) 378-0888 and speak to a member of our staff.

Be Well Solutions works daily to apply public health strategies to workplace wellness and assist in supporting your recommendations and treatment plan.

Thank you in advance for helping your patient in this endeavor.

A handwritten signature in black ink, appearing to read "Ronald Golovan".

Ronald Golovan, MD
Medical Director
Be Well Solutions

Release of Medical Information:

I, _____ grant permission to Dr. _____ to share certain elements of my
(patient name) (physician's name)

health information, specifically laboratory results (cholesterol and glucose measurements), blood pressure measurements, height and weight, with Be Well Solutions. This release will be in effect for two years from the date signed, which allows Be Well Solutions to follow up on any required information. I understand I may retract this permission at any time either verbally or in writing. This information will not be shared directly with my employer. Be Well Solutions, Inc. is a bona fide wellness company and adheres to all such limitations and regulations.

Participant Signature: _____ Date: _____



PHYSICIAN SCREENING FORM

TO BE COMPLETED BY THE PARTICIPANT

FIRST NAME <input style="width:100%; height: 20px;" type="text"/>	LAST NAME <input style="width:100%; height: 20px;" type="text"/>
CELL PHONE <input style="width:100%; height: 20px;" type="text"/>	EMPLOYER <input style="width:100%; height: 20px;" type="text"/>
EMAIL ADDRESS <input style="width:100%; height: 20px;" type="text"/>	
DATE OF BIRTH <input style="width:100%; height: 20px;" type="text"/>	LAST 4 of SSN <input style="width:100%; height: 20px;" type="text"/>

TO BE COMPLETED BY THE PHYSICIAN OFFICE

Physician Name: _____ Signature: _____ Office Phone: _____	Y N Check the box that applies. <input type="checkbox"/> <input type="checkbox"/> HAS THE PATIENT BEEN FASTING FOR THE LAST 8 HOURS? <input type="checkbox"/> <input type="checkbox"/> HAS THE PATIENT BEEN DIAGNOSED WITH TYPE I OR II DIABETES? <input type="checkbox"/> <input type="checkbox"/> HAS THE PATIENT BEEN DIAGNOSED WITH HIGH BLOOD PRESSURE? <input type="checkbox"/> <input type="checkbox"/> IS THE PATIENT CURRENTLY ON BLOOD PRESSURE MEDICATION? <input type="checkbox"/> <input type="checkbox"/> IS THE PATIENT A TOBACCO USER? <input type="checkbox"/> <input type="checkbox"/> IS THE PATIENT PREGNANT?																		
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EMPLOYER CODE

E: _____ C: _____

Deadline: November 2, 2022

Biometric Results must be collected between January 1, 2022 and November 2, 2022 to qualify for the year's program.

SUBMISSION INSTRUCTIONS: — THIS FORM CAN BE:

1. Returned to the patient who must send it to Be Well Solutions.
 2. Emailed to: info@bewellsolutions.com
 3. Faxed to: (440) 498-1366
 4. Mailed to: Be Well Solutions
30625 Solon Rd. Suite C
Cleveland, OH 44139
- Please do not return this form to your employer.**