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.

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

LAST NAME

CELL PHONE ___ — ___ — ____

EMPLOYER BARBERTON

EMAIL ADDRESS

DATE OF BIRTH ___ — ___ — ____

LAST 4 of SSN ____

TO BE COMPLETED BY THE PHYSICIAN OFFICE

Physician Name: _____

Signature: _____

Office Phone: _____

LAB DATE ___ — ___ — ____

Y	N	*Check the box that applies.*
☐	☐	HAS THE PATIENT BEEN FASTING FOR THE LAST 8 HOURS?
☐	☐	HAS THE PATIENT BEEN DIAGNOSED WITH TYPE I OR II DIABETES?
☐	☐	HAS THE PATIENT BEEN DIAGNOSED WITH HIGH BLOOD PRESSURE?
☐	☐	IS THE PATIENT CURRENTLY ON BLOOD PRESSURE MEDICATION?
☐	☐	IS THE PATIENT A TOBACCO USER?
☐	☐	IS THE PATIENT PREGNANT?

GLUCOSE	TOTAL CHOLESTEROL	LDL CHOLESTEROL	HDL CHOLESTEROL	TC/HDL RATIO	TRIGLYCERIDES
___	___	___	___	___.___	____
☐ < 50 ☐ > 500	☐ < 100 ☐ > 500	☐ N/A	☐ N/A ☐ <15 ☐ >100		☐ < 45 ☐ > 650

HEMOGLOBIN A1c*	___.___	*If clinically indicated

BLOOD PRESSURE	HEIGHT (INCHES)	WEIGHT	BMI
___ / ___	___.___	___.___	___.___

EMPLOYER CODE

1	1	9	2

E: _____ C: _____

Deadline: November 2, 2024

Biometric Results must be collected between January 1, 2024 and November 2, 2024 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.