PROVIDER SCREENING FORM - MONTEFIORE

If you received your lab results from a health care provider within the last 6 months please complete this form to determine eligibility and/or update your baseline screening results in the Associate Health Improvement Program. Please scan and upload your completed form to https://montefiore.uswellness.com or fax to 301-337-3232. Receipt of your form will be confirmed within two business days to the email provided below (please print clearly and allow emails from uswellness.com).

STEP 1: To be completed by associate

First Name

Last Name

Street Address

City

State

Zip

EZ-ID

Date of Birth: (Month) (Day) (Year)

Gender: Female Male Non-binary

( ) Phone Number

E-mail address *(to receive e-mail verification that form was received by US Wellness)*

STEP 2: To be completed by associate

I hereby authorize that individually identifiable health information supplied on this form may be released to and maintained by US Wellness and Cerner Wellness for uses and disclosures permitted of covered entities under the federal HIPAA Privacy Rule. I hereby authorize that US Wellness may contact me about health and wellness matters related to this screening program.

X

Employee Signature (REQUIRED)

Date

STEP 3: To be completed by provider office

PREGNANT ◯ Yes ◯ No/ N/A

Please note: Health care provider signature AND stamp are required.

Cholesterol

Total Cholesterol*

HDL Cholesterol

LDL Cholesterol*

Triglycerides

Was patient fasting for more than 8 hours prior to this test? ◯ Yes ◯ No

Date of Test: (Month) (Day) (Year)

Glucose and HbA1c

Glucose

***HbA1c** . %

Was patient fasting for more than 8 hours prior to this test? ◯ Yes ◯ No

Date of Test: (Month) (Day) (Year)

Blood Pressure

Systolic* /

Diastolic*

Date of Test: (Month) (Day) (Year)

Waist Circumference

. inches

Date of Measurement: (Month) (Day) (Year)

Height* (Feet) (Inches)

Weight* (lbs)

Date of Measurement: (Month) (Day) (Year)

* Indicates measurements required in order to receive credit in the Associate Health Improvement Program.

Health Care Provider Name (REQUIRED)

Phone Number

Health Care Provider Signature & Stamp (REQUIRED)

Date

STEP 4: To be completed by associate (recommended) or provider office

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Montefiore USWellness