PHYSICIAN SCREENING FORM – JAMESTOWN REGIONAL MEDICAL CENTER

If you have received the health tests listed below from a health care provider on or after January 1, 2020 you may have the provider complete the bottom part of this form to receive credit in Jamestown Regional Medical Center's wellness program. Please scan and upload your completed form to https://jrmcnd.uswellness.com on or before October 30, 2020. 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 employee or spouse/domestic partner

First Name

Last Name

Street Address

City

State

Zip

Employee

Spouse

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

Gender: Female Male

Phone Number

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

STEP 2: To be completed by employee or spouse/domestic partner

I understand that any individually identifiable health information about me obtained in the course of this screening may be released to and maintained by US Wellness. I authorize US Wellness to share my individually identifiable health information with BCBSND for the purpose of providing wellness services and aggregate population health analysis. I understand that my information will not be shared with my employer. I authorize that US Wellness and BCBSND may contact me and that my information will be managed in accordance with the uses and disclosures permitted of covered entities under the federal HIPAA Privacy Rule.

X

Employee/Spouse/Domestic Partner Signature (SIGNATURE REQUIRED)

Date

STEP 3: To be completed by physician office

PREGNANT ◯ Yes ◯ No

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 (Blood Sugar)

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

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

Waist Circumference

. inches

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

Blood Pressure

Systolic /

Diastolic

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

Height:

(Feet) (Inches)

Weight (lbs):

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

Health Care Provider Name

Health Care Provider Signature

Phone Number

Date

STEP 4: To be completed by employee (recommended) or physician office.

Scan and upload your completed form to https://jrmcnd.uswellness.com on or before October 30, 2020 at 11:59PM CST. Email confirmation will be sent to email address provided above within two business days.

USWellness