Instructions for Receiving Your Health Screening With Your Personal Physician

We are pleased that you are participating in the health screenings this year. **Participation in the health screening is confidential.** Please review these instructions to ensure that your information is complete and sent to the correct location.

See your primary care physician

1. Print the Physician Fax Form.
2. Call your physician to schedule an appointment for your screening.
3. Fill out the Participant Information section of the Data Form.
    a. Please note, your unique ID is your employee ID number or spouse ID.
4. Leave the Data Form with your doctor, and instruct the doctor to fill out the Body Measurements & Biometric Results section of the form.
5. Let the clinic/doctor know that the completed form must be faxed by **May 17, 2017** to:

Wellness Corporate Solutions
Attn: Information Management

SECURE FAX: 1-877-226-3021

You may use screening results obtained from May 15, 2016 – May 13, 2017. **Regardless of screening date, your physician must sign the form. Please fax the form only after all applicable testing has been completed.**

ALL RESULTS MUST BE ENTERED INTO THE APPROPRIATE BOXES ON PAGE 2 OF THIS FORM. SEPARATE FORMS CANNOT BE REVIEWED OR PROCESSED.

If you have any questions please contact support@wellnesscorporatesolutions.com.

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DATA FORM FOR HEALTH SCREENING WITH YOUR PERSONAL PHYSICIAN

LIVE WELL W&L

WASHINGTON AND LEE UNIVERSITY

PARTICIPANT: Complete participant information, bring form to provider for completion. Retain a signed copy for your records.

PROVIDER: Complete Body Measurements & Biometric Results and sign the form. FAX completed form to Wellness Corporate Solutions at **1-877-226-3021** by **May 13, 2017**

I understand that the purpose of my health screening is to evaluate my health status and any potential health risks. I hereby request and authorize Wellness Corporate Solutions, LLC to transmit health information about me to the health management companies that provide services to my employer so that these companies may help me reduce, manage and/or control any such risks. I understand that Wellness Corporate Solutions, LLC is not responsible for diagnosing, treating, or preventing any medical disease or condition that I currently have or may have in the future. I also understand that Wellness Corporate Solutions, LLC will not give me medical advice and that I must seek such advice from my own physician. I understand that Wellness Corporate Solutions, LLC will not provide my employer any health information that identifies me. I acknowledge and agree that Wellness Corporate Solutions, LLC may provide my employer aggregate statistical health information which includes my health information. I understand that Wellness Corporate Solutions, LLC may also use my health information for its own internal business purposes such as to develop future wellness programs. Finally, I understand that I may faint, bruise, or have other effects as a result of my blood being drawn. I voluntarily agree and consent to participate in the health screening and accept and assume all risks associated with such participation. I hereby release and forever discharge Wellness Corporate Solutions, LLC, its owners, employees, and agents from any and all claims, demands, actions, and damages, including attorney's fees and costs, arising out of or in any way related to my participation in the health screening.

PARTICIPANT SIGNATURE (REQUIRED) DATE

PARTICIPANT INFORMATION (TO BE COMPLETED BY THE PARTICIPANT)

FIRST NAME

LAST NAME

DATE OF BIRTH (MM/DD/YYYY) M M / D D / Y Y Y Y

UNIQUE ID#

GENDER: ○ Male ○ Female

RELATIONSHIP: ○ Employee ○ Spouse/Dependent

PHONE NUMBER - -

HOME STREET ADDRESS

CITY

STATE

ZIP CODE

EMAIL ADDRESS

BODY MEASUREMENTS & BIOMETRIC RESULTS (TO BE COMPLETED & FAXED BY PHYSICIAN)

SCREENING DATE M M / D D / Y Y Y Y

FASTING STATUS: ○ Yes ○ No

BODY COMPOSITION & BLOOD PRESSURE		BLOOD TEST RESULTS	
HEIGHT (without shoes)	feet . inches	TOTAL CHOLESTEROL	mg/dL
WEIGHT (without shoes)	. Pounds	HDL CHOLESTEROL	mg/dL
BMI	. kg/m^2	LDL CHOLESTEROL	mg/dL
WAIST	. Inches	TRIGLYCERIDES	mg/dL
BLOOD PRESSURE	/ mmHg	GLUCOSE	mg/dL
NOTES:			

ALL DATA MUST BE PROVIDED ABOVE USING PRE-DEFINED FIELDS. ATTACHMENTS WILL NOT BE REVIEWED OR PROCESSED.

PHYSICIAN SIGNATURE (REQUIRED)

PHONE NUMBER (Provider/Clinic) - -

PLEASE FAX COMPLETED DATA FORM TO: WELLNESS CORPORATE SOLUTIONS, SECURE FAX: 1-877-226-3021