Indiana University Health

2019 - 2020 PHYSICAL VERIFICATION FORM

The patient's physician or medical provider must fax this completed form to Wayne Wellness at 317.536.4006.

Please have your provider complete this physical form and report the values of blood draw (blood pressure, height, weight, waist size/ circumference, fasting glucose, A1C and Lipid Panel [Total Cholesterol, LDL Cholesterol, HDL Cholesterol and Triglycerides]). Only physicals that have been completed from July 1st, 2019 - June 30th, 2020 will be eligible to count towards the 2020 Incentive Program.

** The patient will receive an email from Wayne Wellness confirming the receipt of this form within two week of submission. Should the patient not receive a confirmation it is the patients responsibililty to contact the clinic at 317.536.2200, and then follow up with their physician.*

PARTICIPANT COMPLETE THIS SECTION ONLY

_______________ _______________ _____ ____/____/______

Last Name (Printed) First Name (Printed) MI Date of Birth (mm/dd/yyyy)

Address: ______________________ Phone Number: __________

Email: ______________________ Gender: ☐ Male ☐Female

Employer: ______________________ Last 4 digt SSN: __________

Consent information: This information, along with any personal health information provided in completing the Health Assessment, is maintained in a secure area within IU Health to be used only for calculating this incentive. It is not shared with your employer. IU Health will provide your employer aggregate information as part of a group summary report (individual data results will not be disclosed.) IU Health uses some of its subsidiaries, affliates, and other agents to carry out the work of its wellness program.
To the extent it is necessary, I hereby consent to such release for these agents, employees and/or clinical providers of IU Health to have access to my health screening information in order to carry out their duties. By submitting this form, I hereby consent to use of my biometric screening information for the pruposes specified above, and grant any wellness program associated permission to contact me regarding my results.

Signature of Patient: ______________________ Date: ___/___/___

THIS SECTION TO BE COMPLETED BY MEDICAL PROVIDER PERFORMING PHYSICAL

Date of Physical ____/____/______

Height (inches): __________

Weight (lbs.): __________

BMI: ________

Blood Pressure: __________
*less than or equal to 120/80

Waist Size/Circumference: __________

* *values required to meet 2020 incentive program*

Total Cholesterol: __________

HDL Cholesterol: __________

Triglycerides: __________
**less than or equal to 150 mg.*

LDL: __________

Non-HDL: __________

TC/HDL Ratio: __________

A1C: __________ **less than or equal to 5.7*

Fasting Glucose: __________

Fasting: ☐ Yes ☐ No

Smoke: ☐Yes ☐ No

Pregnant or Post-Partum (up to one year)

☐ Pregnant

☐ Post-Partum

Delivery Date: ____ / _____ / _____

(Optional) Physician Notes:

Provider's Signature: ______________________

Date: ____/____/______ Provider's Name (Printed): ______________________

Phone Number: __________

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