HealthCheck360

# PHYSICIAN WELLNESS SCREENING RESULTS FORM

Upload to your myHealthCheck360.com account by: 11/15/21

Only lab results from 06/01/21 to 11/15/21 will be accepted.

## PARTICIPANT INFORMATION (COMPLETED BY PATIENT – PLEASE PRINT)

EMPLOYER NAME: TPI Composites

LOCATION CODE: TPCMP

UNIQUE ID:

PHONE NUMBER: ___-___-____

EMPLOYEE (P) / SPOUSE (D): ☐ P ☐ D

PREGNANT: ☐ Y ☐ N

LEGAL LAST NAME:

LEGAL FIRST NAME:

SEX: ☐ M ☐ F

DATE OF BIRTH: __/__/____

EMAIL ADDRESS:

ADDRESS:

CITY:

STATE:

ZIP:

**PARTICIPANT SIGNATURE:** _____ **DATE:** _____

**RELEASE OF HEALTH INFORMATION:** By submitting this form, I am requesting my physician to report my biometric and laboratory results to HealthCheck360 to be included as part of an employer sponsored wellness program. By signing below, I authorize the release of my personal health information and preventive health screening results listed on this form by my health care provider. This authorization shall remain in force for 12 months following the date of my signature below and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification. I understand that all fields must be completed in order for my form to be accepted.

## REQUIRED TO PROCESS RESULTS

**HEIGHT (INCHES)** ___ INCHES

**WEIGHT (LBS.)**

**WAIST (INCHES)**

**BLOOD PRESSURE** ___/___

**BLOOD PRESSURE (IF 1ST > 120/80)** ___/___

**LAB DATE** __/__/__

**TOTAL CHOLESTEROL**

**HDL**

**LDL**

**TRIGLYCERIDES**

**GLUCOSE**

**EXAMINATION DATE** __/__/__

DOES PATIENT SMOKE, USE TOBACCO PRODUCTS OR NICOTINE SUBSTITUTES? ☐ Y ☐ N

## PHYSICIAN INFORMATION

Your patient is a participant in a health and wellness program sponsored program through their employer or spouse's employer. Through this wellness program, your patient has an opportunity to improve their health risks as they exhibit healthy lifestyle choices. This program is not intended to treat, diagnose or replace physician involvement, but rather to create and promote an atmosphere of healthy living and learning.

PHYSICIAN CLINIC:

PHONE NUMBER: ___-___-____

**PHYSICIAN'S SIGNATURE:** _____

**PHYSICIAN'S NAME (PLEASE PRINT):** _____

Email: Support@HealthCheck360.com | Phone: 866-511-0360 | Fax: 563-587-5720