

Dear Physician and/or Clinician,

The patient listed below is participating in an employer-sponsored health-management program administered by The McCahill Group, which includes submitting proof of an annual physical examination and a fasting biometric profile.

**Please complete this form, providing all of the required information below and return it to The McCahill Group before October 31, 2020. All results provided will remain private and will not be shared with your employer.**

## 1. PATIENT INFORMATION (TO BE COMPLETED BY EMPLOYEE)

Patient's Name: \_\_\_\_\_ Male  Female  DOB: \_\_\_\_\_

Patient's Email: \_\_\_\_\_

Patients phone number: \_\_\_\_\_

**I authorize the clinician's office completing this form to release the information below to The McCahill Group.**

Patient's signature: \_\_\_\_\_

## 2. TEST RESULTS (TO BE COMPLETED BY CLINICIAN) Biometrics must be completed between 11/1/2019 and 10/15/2020

TEST	RESULT	Fasting Status: <input type="checkbox"/> Fasting <input type="checkbox"/> Non-fasting
Total Cholesterol	_____ mg/dl	Cholesterol Meds: <input type="checkbox"/> Yes <input type="checkbox"/> No
HDL	_____ mg/dl	
LDL	_____ mg/dl	
Triglycerides	_____ mg/dl	
Glucose	_____ mg/dl	Diabetic Meds: <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Pressure	_____ mmHg	BP Medications: <input type="checkbox"/> Yes <input type="checkbox"/> No
Height	_____ inches	Weight _____ pounds
BMI	_____ (nn.n format)	
<b>Does the above listed patient use tobacco products?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No

## 3. PHYSICIAN OR CLINICIAN SIGNATURE (FORM NOT VALID UNLESS SIGNED)

Date of testing/measurements: \_\_\_\_\_

Physicians Name: \_\_\_\_\_

Signature of Office Staff completing form: \_\_\_\_\_ Date: \_\_\_\_\_

Office phone number: ( \_\_\_\_\_ ) \_\_\_\_\_