Annual Health Screening Form

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 your Wellness Team before October 31st, 2019. All results provided will be 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 11/1/18 and 10/31/19

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