

Elevate Wellness - Physician Health Screening Form

INSTRUCTIONS

1. Have your health care provider complete all sections of the form with the most recent biometric data. Include the date the values were obtained.
2. Email, fax, or mail the form to Elevate Wellness, a Magellan Rx Management program.
The information is gathered by our team on behalf of EMI Health. Neither your employer nor EMI Health receives this form. Please do not send this form to your company's Human Resources. Email it to: wellness@magellanhealth.com.
3. You will receive an email reply from the Elevate Wellness team confirming receipt of the form.
4. Within 10 business days after the form is received by the Elevate Wellness team, you will receive an email from www.mybiocheck.com with a report card for reference.
5. You will receive an outreach call from our wellness coach, so you can ask questions about your report, discuss your health numbers and what they mean, and get support with meeting your health and wellness goals. Calls are confidential and no additional cost to EMI Health members.

Elevate Wellness - Physician Health Screening Form

Participant Name: _____ DOB: _____

Email: _____

Address: _____

Phone: _____

Company: _____

Circle One: Male / Female

For Women: Are you current Pregnant? Yes / No

Are you Fasting? Yes / No

Do you currently Smoke? Yes / No

Do you have a Primary care Physician? Yes/No

Have you had a preventative care exam in the last 12 months? Yes/No

PERSONAL BIOMETRIC VALUES
WAIST MEASUREMENTS (inches)
HEIGHT (feet/inches)
WEIGHT (LBS)
BLOOD PRESSURE (MMHG)
GLUCOSE BLOOD SUGAR (mg/dL)
TOTAL CHOLESTEROL (mg/dL)
HDL (mg/dL)
LDL (mg/dL)
TRIGLYCERIDES (mg/dL)

Please read the follow disclosure state: By signing this form I certify the participant completed a general health assessment for the above listed measures. I provided information about any high-risk numbers as appropriate.

Date Completed: _____

Health Care Providers Name (Printed): _____

Health Care Providers Signature: _____