Physician Form

Upload or fax(240-477-1636) your completed form to michaels.uswellness.com on or before 6/30/2024.

First Name: Last Name: DOB :

I understand that any individually identifiable health information about me obtained in the course of this screening may be released to and maintained by US Wellness with third party vendors engaged or designated by my employer to: (a) inform me of relevant health related and health education programs, (b) administer any incentive offered by my employer or for the purpose of providing wellness services and analysis. I understand that my information will not be shared with my employer. I authorize that US Wellness may contact me and that my information will be managed in accordance with the uses and disclosures permitted of covered entities under the federal HIPAA Privacy Rule. I may revoke this authorization through written communication to privacy@uswellness.com. Revocation of this consent will apply to data sharing that has not yet occurred at the time of the revocation. By signing below, I acknowledge that I have read, understand, and accept all of the statements on this consent form.

Participant signature:_____Date:_____

To be completed by physician office

PREGNANT ☐ Yes ☐ No

Cholesterol

Total Cholesterol ☐☐☐

HDL Cholesterol ☐☐☐

LDL Cholesterol ☐☐☐

Triglycerides ☐☐☐

Patient fasting?

☐ Yes ☐ No

Date of Test:

☐☐ (Month) ☐☐ (Day) ☐☐☐☐ (Year)

Glucose ☐☐☐ or HbA1c ☐☐.☐

Patient fasting?

☐ Yes ☐ No

Date of Test:

☐☐ (Month) ☐☐ (Day) ☐☐☐☐ (Year)

Waist Circumference

☐☐.☐

Date of Measurement:

☐☐ (Month) ☐☐ (Day) ☐☐☐☐ (Year)

Blood Pressure

Systolic ☐☐☐

Diastolic ☐☐☐

Date of Test:

☐☐ (Month) ☐☐ (Day) ☐☐☐☐ (Year)

Height: ☐☐ (Feet) ☐☐ (Inches)

Weight(lbs): ☐☐☐

Date of Measurement:

☐☐ (Month) ☐☐ (Day) ☐☐☐☐ (Year)

Healthcare provider name: Phone:

Healthcare provider signature: Date: