Wellbeing Screening Results- Physician Form
Teamsters Local 731

Dear Physician,

Your patient is participating in a voluntary health risk appraisal (including biometric screening) provided through their employer (or spouse's employer). This program is designed to educate, encourage and enable your patient to adopt and maintain behaviors related to a healthy lifestyle. As a portion of this program, your patient has been asked to visit their personal physician to complete a full biometric screening panel including a CMP, CBC and Lipid panel. Please see the following sections of this document for the patient attributes required for this program. Please note that all personal health information collected through this program shall remain confidential and not be shared with anyone, including the sponsoring employer. The employer will only be told the patients incentive level in order to provide the incentive tied to the patient's health status. The employer will never be provided with a patient's specific health information.

Please ensure that you provide all data in the "REQUIRED INFORMATION" Sections 1 & 2. The biometric information requested in Section 3 is strongly recommended since your patient will be able to trend these biometric factors over time on their personal health portal that is provided as a part of this program.

Physician Verification

I hereby certify that the patient, listed below, is under my care and that the biometric information provided below is up to date and accurate.

Patient Information

Full name (please print):		Last 4 of SSN:	
Phone Number:		Company Name:	
Date of Birth (mm/dd/yyyy):		Gender:	☐ Male ☐ Female

Section 1: Patient attributes (REQUIRED INFORMATION)

Weight:	_____lbs.	Waist Circumference:	_____inches
Height:	_____feet _____inches	Blood Pressure:	(Sys.) _____/(Dia.) _____

Section 2: Patient attributes (REQUIRED INFORMATION)

Test:	**Results:**	**Test:**	**Results:**
Glucose	_____ mg/dL	Triglycerides	_____ mg/dL
Cholesterol, Total	_____ mg/dL	HDL Cholesterol	_____ mg/dL
		LDL Cholesterol	_____ mg/dL

Section 3: Patient attributes (STRONGLY RECOMMENDED*)			
Test:	**Results:**	**Test:**	**Results:**
*Uric Acid	_____ mg/dL	*Blood Urea Nitrogen (BUN)	_____ mg/dL
*Creatinine	_____ mg/dL	*BUN/Creatinine Ratio	_____
*Protein, Total	_____ g/dL	*Albumin	_____ g/dL
*Bilirubin, Total	_____ mg/dL	*Bilirubin, Direct	_____ mg/dL
*Alkaline Phosphatase	_____ IU/L	*AST (SGOT)	_____ IU/L
*ALT (SGPT)	_____ IU/L	*Iron	_____ ug/dL
*Hemoglobin	_____ g/dL	*Hematocrit	_____ %
Sodium	_____ mmol/L	GGT	_____ IU/L
Potassium	_____ mmol/L	Total Cholesterol/HDL Ratio	_____
Chloride	_____ mmol/L	WBC	_____ x10E3/uL
Carbon Dioxide	_____ mmol/L	RBC	_____ x10E3/uL
Calcium	_____ mg/dL	MCV	_____ fL
Phosphorus	_____ mg/dL	MCH	_____ pg
Globulin	_____ g/dL	MCHC	_____ g/dL
Albumin/Globulin Ratio	_____	RDW	_____ %
LDH	_____ IU/L	Platelets	_____ x10E3/uL

Physician Information & Signature			
Physician Name (printed):			
Physician's Signature:		Date:	
Physician's Work Phone:			
Physician's TIN #:			
Date of Lab work:			

Physician Comments (optional)
Please use the space below to make any additional comments.

Physician Instructions: Fax the completed form to CHC Wellbeing at 847-437-2775 by 1/31/2027.

Participant Instructions: Mail the completed form to CHC Wellbeing – Attn: Daisy Garcia (Operations) – 8755 West Higgins Rd., Suite 300 – Chicago, IL 60631