3 Ways to Screen

HealthWorks
Building **Healthy** Worksites

Determine the screening option(s) that are being offered by your employer (all 3 may not be available to you). Be sure to have the correct paperwork and required verification for credit.

AT YOUR WORKSITE

After your worksite screening, schedule a well-check visit and have your physician complete the **'Annual Physical Verification'** section of your form. Return it to HealthWorks.

AT LABCORP

After your Labcorp screening, schedule a well-check visit and have your physician complete the **'Annual Physical Verification'** section of your form. Return it to HealthWorks.

AT YOUR PHYSICIAN

Following your physician screening, have your physician complete the **'Patient Results'** section of your form and return it to HealthWorks.

QUESTIONS?

513-751-1288
info@cincyhealthworks.com

OFFSITE SCREENING RESULTS FORM **Fort Recovery Industries**

HealthWorks
Building **Healthy** Worksites

Form for appointments between 1/1/2024 – 8/31/2024 will be accepted if submitted NO LATER THAN 8/31/2024

SECTION 1: PERSONAL INFORMATION (must be completed by patient)

PLEASE CHECK ONE BOX ONLY:

☐ **My screening was done at my doctor's office, so my doctor must complete section 2 only.**

☐ **My screening was done at my worksite or a Labcorp location, so my doctor must complete section 3 only.**

Full Name :
(USE CAPITAL LETTERS)

Date Of Birth : ______/______/______ **Gender** : ☐ Male ☐ Female

Home Address : ______

Phone Number : ______ **E-Mail** : ______

Insurance ID# : ______ **Last 4 SSN** : ______

INFORMATION CONSENT

I, ______________________ (patient name), grant permission to Dr. ________________(physician name) to share my lab results, blood pressure, height, weight, and waist circumference measurements with HealthWorks. I understand that my information will not be shared directly with my employer and that HealthWorks adheres to all HIPAA regulations.

Patient Signature: ______ **Date:** ______

SECTION 2: PATIENT RESULTS (physician screenings - completed by physician)

Fasting : ☐ Yes ☐ No **Tobacco User** : ☐ Yes ☐ No

Pregnant : ☐ Yes ☐ No **Diabetic** : ☐ Yes ☐ No

Glucose : ☐☐☐

Total Cholesterol : ☐☐☐

Triglycerides : ☐☐☐

HDL : ☐☐☐

LDL : ☐☐☐

A1-C : ☐☐☐

Blood Pressure : ☐☐☐ Systolic
: ☐☐☐ Diastolic

Height : ☐☐☐ Inches

Weight : ☐☐☐ Pounds

Waist : ☐☐☐ Inches

Physician Name :

Physician Address : ______

Phone Number : ______

Physician Signature : ______ **Date** : ______

SECTION 3: ANNUAL PHYSICAL VERIFICATION (for worksite or LabCorp screenings)

I, ____________________ (Physician Name), conducted an annual physical/well-check office visit for the patient listed above. This visit was completed on ______________________(Date).

Physician Signature: ______ **Date:** ______

Submit Form to HealthWorks:

- Scan/Email to: offsite@cincyhealthworks.com
- Fax to: (513) 751-0018
- Mail to: HealthWorks, 4350 Glendale-Milford Road, Suite 110, Blue Ash, OH 45242
- Questions? Call 513-751-1288 or email us at offsite@cincyhealthworks.com