

Health Care Provider Wellness Exam Verification Form

INSTRUCTIONS FOR SUBMITTING SCREENING RESULTS:

To submit screening results from your physician's office, complete all information below, including the Screening Results section, and then fax this page to the LiveWell health center via fax **(913) 825-8590**. Screening results can be submitted if obtained **within the last 8 weeks**.

Dear Physician:

City of Lenexa values the health and well being of its employees. A number of resources & programs are provided to promote wellness, including access to an online health tracking system, an Employee Assistance program, an onsite health clinic, and other preventive benefits.

As part of City of Lenexa health and wellness initiative, employees are encouraged to visit their physician for an annual exam or participate in a free on-site health screening. Employees are encouraged to *know, compare, and if needed, improve* their base health numbers from one year to the next. With test results, City of Lenexa hopes that employees will engage in a discussion with their physician about any test which may be out of range.

Please support City of Lenexa's efforts by communicating with your patient the importance of preventative health and controlling risk factors. As part of the health assessment you perform today, please include the tests listed below.

The City of Lenexa's Wellness Coordinator would be happy to answer any questions that you or the employee may have regarding the wellness program and resources. They may be reached at 913-477-7548 or via e-mail at edaniels@lenexa.com.

**Sections required to receive credit for labs/biometrics*

*Employee Name _____
Last Name (Print) First Name Middle Initial

Employee Home Phone (____) _____ *Employee Date of Birth _____
(Month / Day / Year)

Screening Results:

*Date of Screening _____ *Health Care Provider Signature _____
(Month / Day / Year)

*Total Cholesterol: _____ *HDL Cholesterol: _____ HDL Ratio _____ *LDL Cholesterol: _____

*Triglycerides: _____ *Fasting Glucose: _____ *Systolic/Diastolic Blood Pressure: ____/____

PSA (males only if indicated): _____ Thyroid (females only if indicated): _____

*Height: _____ (inches) *Weight: _____ (pounds) *Waist: _____ (inches) Neck _____ (inches)

Body Fat % _____ (optional)

Note: Normal turnaround time is 1 week from the time of submission before the results are viewable in your LiveWell Wellness and Patient Portals.

Confidentiality Notice: Confidential Health Information Enclosed

Protected Health Information (PHI) is personal and sensitive information related to a person's healthcare. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure and confidential manner. Re-disclosure without additional patient consent or as permitted by law is prohibited. Unauthorized redisclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.

IMPORTANT WARNING: This message is intended for the use of the person or entity to which it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If you are not the intended recipient, or the employee or agent responsible to deliver it to the intended recipient, you are hereby notified that any disclosure, copying or distribution of this information is Strictly Prohibited. If you have received this message by error, please notify the sender immediately to arrange for return or destruction of these documents.