CHC WELLBEING

WELLNESS MATTERS

BEYOND WELLNESS TO TRUE POTENTIAL

Physician Wellbeing Assessment Guide

866.373.4242 www.chcw.com info@chcw.com

LLCC's Physician Option Screening

Visit your physician and submit your test results by October 31, 2017

LLCC wants to help you move forward with your health goals in 2017, and that journey starts with a voluntary, private and easy wellbeing assessment!

Any benefit-eligible employee and spouse not able to attend the onsite screening is encouraged to visit their personal physician and submit their test results.

Each employee that participates in the screening will receive a $50 VISA gift card. Spouses are not eligible for this incentive.

1. Go to www.chcw.com and click on 'Member Login.' If you've screened with CHC Wellbeing before, enter in your username and password in the 'Individual' box. Once you have logged in, enter in program code 3477Lin197 to join the new program, and then click on 'Schedule Your Screening' to start registration.

2. If this is your first time screening with CHC Wellbeing, enter in program code 3477Lin197 in the 'New Participants' box. Follow the prompts to complete your registration and Health & Lifestyle Survey.

3. When prompted to select a location, click on "Remote" for your screening appointment. To complete your registration process, **bring the following two pages of this guide to your physician and have them complete the required tests and fax the results to CHC Wellbeing by October 31, 2017.**

DON'T FORGET!

This is a fasting test! For precise results, please fast 10-12 hours before testing. You cannot eat but may have water, black coffee or tea (no cream or sugar). If you are on prescription medication, please take your medication as instructed by your physician. Consult your physician if you are diabetic or hypoglycemic.

Wellbeing Screening Results- Physician Form

Lincoln Land Community College

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's 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
HDL Cholesterol	_____ mg/dL	WBC	_____ x10E3/uL
LDL Cholesterol	_____ mg/dL	RBC	_____ x10E3/uL
Cholesterol, Total	_____ mg/dL	Platelets	_____ x10E3/uL

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

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.

Fax the completed form to CHC Wellbeing at 847-437-2775 by October 31, 2017.