Deaconess Clinic
WELLNESS SOLUTIONS

Physician Screening Form

Company Name: **OLD NATIONAL BANK** **Circle**: Employee or Spouse **Circle**: Male or Female

Participant Name (Printed)____ Daytime phone #____________

Address:____ Email_____________________

Birthdate____________ Last 4SSN #_____________ Employee#/Clock #__________________

In the last 6 months, have you used tobacco or nicotine substitute products, including but not limited to: cigarettes, pipes, cigars, snuff, chewing tobacco, nicotine gum, nicotine patch, e-cig, vaping, or any other nicotine supplements?

YES NO If quit, please list date___________________

Are you pregnant or have you had a baby in the last year? YES NO

Are you diabetic YES NO

I authorize Deaconess Clinic Wellness Solutions to release my name to my place of employment for the purpose of confirming participation, and, if required, whether care plan objectives were met or number of risk factors in the wellness program.

The information will be stored in a system called Applied Health Analytics which will have restricted access to secure protected information. The information you provide will be kept strictly confidential and will not be shared with your insurance carrier. Your employer will not be provided any other personal information about you expect as aggregate data that does not identity any single individual. I understand that I can refuse or revoke this authorization; however, if I do so, I will not qualify for the incentive, should my company offer one. I understand that revocation will not apply in those instances specific in the applicable Notice of Privacy Practices of which I was offered at the time of my screening. If I revoke this authorization I must do so by sending my request in writing to Deaconess Clinic Wellness Solutions. I understand that the material released as a result of this authorization may be subject to re-disclosure and no longer protected by the laws applying to medical information release. This authorization will expire 60 days after date signed unless otherwise specific as follows: 1 year. In addition, I have been offered a copy of Deaconess HIPAA Privacy Form.

Participant Signature______________________________ Date_________________________

Dear Physician:
Your patient is a participant in the Deaconess Clinic Wellness Solutions Wellness Program through his/her work. The staff at DC Wellness Solutions performs a yearly health screening including the following tests/measurements:

	RESULTS		RESULTS
Total Cholesterol		*Blood Sugar F or NF Diabetic: Y or N	
*LDL (bad) Cholesterol		*Blood Pressure	
HDL (good) Cholesterol		*Height	
*TC/HDL Risk Ratio		*Weight	
Triglycerides		*Body Mass Index	

Lab work date:__________________

**These results are used for your patient to be eligible for the company wellness incentive.*

Your patient has chosen to have the above obtained at your office. Please provide these results and fax to:
Deaconess Clinic Wellness Solutions
Confidential Fax: 812-450-6027

Physician/Medical Representative

_____________________________________ _____________________________________

Signature **Date**