**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 1/31/2026.

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