

3 Ways to Screen

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

Sinclair- Deadline: 12/31/2024

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 of Tartan ID : _____

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 :

LDL :

Height : Inches

Total Cholesterol :

A1-C :

Weight : Pounds

Triglycerides :

Blood Pressure :

Waist : Inches

HDL :

Systolic

Diastolic

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