

2021 - AHA Outside Provider Screening Form

CareHere!

Participant Instructions:

Please have your outside medical provider complete this form fully for you to be compliant with the voluntary wellness program

- **AHA – Annual Health Assessment** - The goal of this program is for the patient to complete an annual medical evaluation.
- Providing medical data to CareHere is not required for compliance, we need patient identifiers for tracking purposes.
- **DO NOT fax copies of labs** – please see lab instructions below.
- CareHere personnel will not be responsible for contacting an outside provider or patients to correct an incomplete/incorrect Biometric screening form. Please confirm the form is correct before faxing.
- It is the patient's responsibility to confirm their compliance online, on phone app, or with Montgomery Water Works. Please email questions to Becky Story at bstory@mwwssb.com
- This form is for the 11/01/2020 – 10/31/2021 program
- Please fax this completed form to CareHere at 334.356.3681 before October 31, 2021

Provider Instructions:

Your patient is participating in the Montgomery Water Works Wellness Program that includes biometric measurements, blood draw, and lab follow up with provider.

Please print clearly in **CAPITAL LETTERS** and fill out each blank space area using an ink pen (*required)

*PATIENT INFORMATION (Employee _____ or Spouse X)

*Patient's Last Name: Buckalew *Patient's First Name: Rebecca *Gender: F

*Patient's Phone #: (334) 318 - 2420 *Patient's DOB: 04/11/1977 *Date of AHA or Follow-up: / /

BIOMETRICS If required biometrics not medically recommended, please indicate reason _____

*Height: 5 feet 0 inches *Weight: 123 pounds
*Blood Pressure: 123 / 83 *Waist Circumference (at navel level): 31" inches

Blood Panel – please check tested labs

- | | | | |
|---|--|--|---|
| ☐ *Total Cholesterol | ☐ Chloride (Cl) | ☐ Phosphorus, Serum | ☐ Lactate Dehydrogenase Enzyme |
| ☐ LDL Cholesterol | ☐ Carbon Dioxide (CO2) | ☐ Magnesium, Serum | ☐ Albumin, Serum |
| ☐ HDL Cholesterol | ☐ Blood Urea Nitrogen (BUN) | ☐ Aspartate Aminotransferase Enzyme | ☐ Protein, Total, Serum |
| ☐ T. Chol/HDL Ratio | ☐ Creatinine (Creat) | ☐ Alanine Aminotransferase Enzyme | ☐ Globulin, Total |
| ☐ Triglycerides | ☐ BUN/Creatinine Ratio | ☐ Gamma Glutamyl Transferase Enzyme | ☐ Prostate Specific Antigen, Serum |
| ☐ Sodium, Serum | ☐ *Glucose, Serum | ☐ Bilirubin, Total | ☐ Iron, Serum |
| ☐ Potassium, Serum | ☐ Calcium (Ca) | ☐ Alkaline Phosphatase, Serum | ☐ Uric Acid, Serum |

SIGNATURES

*Provider's Name: (print) Lindsey Barten *Provider's Signature: [Signature]
*Office Phone: (334) 244-3281 *Date: 10/29/21

PATIENT SIGNATURE REQUIRED FOR PROGRAM PARTICIPATION

By signing, I authorize the disclosure of my health screening results to CareHere, LLC.
All information released to CareHere will be protected in accordance with any applicable law.

Patient's name: (print) Rebecca Buckalew Patient's Signature: R. Buckalew

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