Annual Wellbeing Visit Provider Form

Participant Name:	
Employer:	
Date of Birth:	**Last 6 digits** of social security number:
Phone number:	Email address:

Your health care provider's office must complete this form attesting to the results of the below biometric screening requirements. You must also complete the HRAQ located in the Screening Tab to earn any incentives.

The completed form should be emailed to service@inhealth4change.com no later than June 30.

Biometrics	
Height (in):	
Weight (lbs):	
Waist (in):	
BMI:	
Blood pressure:	
Pulse:	

Lab Results		
Fasting?	Yes	No
Blood glucose*:		
A1c*:		
Total cholesterol:		
HDL:		
LDL:		
Triglycerides:		

Annual Primary Care Wellness Visit		
Participant has completed an annual wellness visit with a primary care provider	Yes	No
Tobacco Status		
Participant has used tobacco products, including e-cigarettes, in the past 3 months:	Yes	No

Health Care Provider Name: ____

Health Care Provider Signature: ______________________________**Date:** ___________

**Blood glucose and/or a1c can be provided. Only one or the other is needed for the Health Risk Assessment.*