Instructions for Receiving Your Health Screening
With Your Personal Physician

Employees have the option to visit their personal physician if they cannot attend the onsite Villanova health screenings.

We are pleased that you are participating in the health screening this year. Participation in the health screening is confidential. Please review these instructions to ensure that your information is complete and submitted to the correct location.

See Your Primary Care Physician

1. Call your physician to schedule an appointment for your screening OR if you already have lab results from your physician visit dated between June 1, 2011 and April 30, 2012, you may ask your physician to submit those results with the data form on page two.

2. Fill out the top portion of the data form provided with this package and bring it to the screening.

3. Leave the Data Form on page two with your doctor. It will be filled out and faxed directly to Wellness Corporate Solutions to ensure confidentiality.

4. If you are interested in earning a $300 incentive towards 2012 medical premiums (defined as completion of the health screening and personal health assessment), complete the online Personal Health Assessment by visiting the wellness portal at villanovauniversity.livehealthier.com and going to the Take Your Personal Health Assessment: Identify Your Health Risks page, accessible from the “What Do You Want To Do?” action center on the right side of the screen.

Please stress to the clinic/doctor to send the completed Data Form to Wellness Corporate Solutions no later than April 30, 2012.

Fax completed Data Form to:

Wellness Corporate Solutions
Secure Fax: (888) 677-3457
Phone: 877-469-5411
DATA FORM FOR HEALTH SCREENING WITH YOUR PERSONAL PHYSICIAN

Consent and Release: In consideration of my voluntary participation in this biometric health screening which requires at a minimum, a finger-stick Cholesterol/Glucose Screening, I understand and agree to the following: While under no obligation, participation in this program may include taking personal medical history and health information, or referring me to a doctor or other provider for medical care. A risk assessment is not a guarantee of good health, and participation in this program cannot substitute for consultation with a physician for any medical or health-related condition, or for a regular physical exam. I hereby indemnify the host and sponsor of this program and Wellness Corporate Solutions (WCS), their employees, agents, and representatives from any claims, losses, liability of any kind, or damages, including but not limited to illness or personal injury arising in any way from my voluntary participation in this program. All medical information obtained through my participation in this program will be kept confidential and will be used for data collection and reporting in aggregate format. I understand and agree that my screening information will be shared with the screening company WCS.

Name ___________________________________________ Signed ___________________________ Date________________

TO BE COMPLETED BY PATIENT

Please print information

Patient Name: ___________________________________________ Gender: F _____ M _____

Home Address: _______________________________________________________________________________________________________

(Street) (City) (State) (Zip)

Date of Birth: _____/_____/_______ Email: _____________________________ Phone: ______-____-____

MM DD YYYY

Last four digits of patient Social Security Number: ____________

TO BE COMPLETED BY PHYSICIAN

Date of Visit ________________________

Fasting: ☐ Yes ☐ No

Height (without shoes) _______ inches Weight (without shoes) _________ pounds

BMI: __________ Waist: _______ inches Hip: _______ inches Waist/Hip Ratio: _______

Blood Pressure: _______/_______ 2nd Reading Blood Pressure: _______/_______

Lipid Profile

Total Cholesterol: ______________ HDL: __________ LDL: __________ TRIG: __________

Chol/HDL Ratio: ______________ Blood Sugar: ______________

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