

# PHYSICIAN SCREENING FORM – KWIK TRIP

If you have received the health tests listed below from a health care provider on or after 9/1/2023 you may have the provider complete the bottom part of this form to receive credit in Kwik Trip's My Wellbeing Journey program. Please fax your form to 608-420-6618 on or before 8/31/2024. **NOTE! It is highly recommended that you send your completed form to ViaroHealth directly. DO NOT rely on your physician's office to send it for you.**

## STEP 1: To be completed by Coworker or spouse

<input type="text"/> First Name	<input type="text"/> Last Name	
<input type="text"/> Street Address		
<input type="text"/> City	<input type="text"/> State	<input type="text"/> Zip
( <input type="text"/> ) <input type="text"/> <input type="text"/> Phone Number	Date of Birth: <input type="text"/> <input type="text"/> <input type="text"/> (Month) (Date) (Year)	
<input type="text"/> Coworker ID #	<input type="checkbox"/> Coworker	<input type="checkbox"/> Spouse
Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male		
<input type="text"/> E-mail address		

## STEP 2: Both Coworker and on plan spouse must complete form separately (signature required)

I understand that any individually identifiable health information about me obtained in the course of this screening may be released to and maintained by ViaroHealth. I understand that my information will not be shared with my employer. I authorize that ViaroHealth may contact me and that my information will be managed in accordance with the uses and disclosures permitted of covered entities under the federal HIPAA Privacy Rule.

All sections must be completed for coworkers and spouses to be eligible to receive credit for the wellness incentive.

**X**

Coworker/Spouse Signature (SIGNATURE REQUIRED)

Date

## STEP 3: To be completed by physician office

PREGNANT  Yes  No (N/A)

**Note: The form needs to be completed in full for full credit of the program.**

Date of Laboratory Testing: \_\_\_\_\_

<b>Cholesterol</b> Total Cholesterol <input type="text"/> HDL Cholesterol <input type="text"/> LDL Cholesterol <input type="text"/> Triglycerides <input type="text"/> TC/HDL Ratio <input type="text"/> . <input type="text"/> Was patient fasting for more than 8 hours prior to this test? <input type="radio"/> Yes <input type="radio"/> No	<b>Glucose</b> <input type="text"/> Was patient fasting for more than 8 hours prior to this test? <input type="radio"/> Yes <input type="radio"/> No	<b>Blood Pressure</b> Systolic <input type="text"/> / <input type="text"/> Diastolic <input type="text"/>
Was patient fasting for more than 8 hours prior to this test? <input type="radio"/> Yes <input type="radio"/> No	<b>Waist Circumference</b> <input type="text"/> inches	<b>Height:</b> <input type="text"/> (Feet) <input type="text"/> (Inches) <b>Weight (lbs):</b> <input type="text"/>

**X**

Health Care Provider Name

Health Care Provider Signature

Phone Number

Date

## STEP 4: To be completed by coworker or spouse

**Fax completed form to 608-420-6618 or upload to <https://www.viarohealth.com/medical-record-upload/> on or before 8/31/2024 at 11:59pm CST.**

