

STRATAIR Health Screening Form

IF YOU HAVE A COPY OF YOUR LAB RESULTS

- Complete *Participant Information & Signature* section
- Obtain a copy of your lab results
- Complete *Health Results* section
- Submit screening form *with lab results*

IF YOU DO NOT HAVE A COPY OF YOUR LAB RESULTS

- Complete *Participant Information & Signature* section
- Have Provider complete *Health Results* section
- Have Provider complete *Provider Signature* section
- Submit screening form

PARTICIPANT INFORMATION

<p>First Name</p> <input style="width: 100%; height: 20px;" type="text"/>	<p>MI</p> <input style="width: 20px; height: 20px;" type="text"/>	<p>Last Name</p> <input style="width: 100%; height: 20px;" type="text"/>
<p>Date of Birth</p> <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 20px; height: 20px;" type="text"/> / <input style="width: 40px; height: 20px;" type="text"/> <p style="font-size: small;">(Month) (Day) (Year)</p>	<p>Gender</p> <input style="width: 40px; height: 20px;" type="text"/> <p style="font-size: small;">M/F</p>	<p>Unique ID</p> <input style="width: 100%; height: 20px;" type="text"/> <p style="font-size: small;">(Last 2 digits birth year and last 4 SSN)</p>
<p>Daytime Phone #</p> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 40px; height: 20px;" type="text"/>	<p>Email Address <i>(Confirmation will be sent to this email address)</i></p> <input style="width: 100%; height: 20px;" type="text"/>	

PARTICIPANT SIGNATURE

By signing and faxing this form, I understand that my data will be shared with the administrator of the applicable wellness program. My individual results will NOT be shared with my employer. Vivacity is committed to maintaining the confidentiality of your medical information.

This form will not be accepted without a participant signature.

Participant Signature: _____

(Month)	(Day)	(Year)	

HEALTH RESULTS

<p>Height</p> <input style="width: 20px; height: 20px;" type="text"/> ft <input style="width: 20px; height: 20px;" type="text"/> in	<p>Weight</p> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> lbs	<p>Fasting</p> <input style="width: 20px; height: 20px;" type="text"/> Yes <input style="width: 20px; height: 20px;" type="text"/> No	<p>Glucose</p> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
<p>Cholesterol</p> <p>HDL: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> <p>LDL: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p>	<p>TRI: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p> <p>Total: <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/></p>	<p>Blood Pressure</p> <p><input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Systolic</p> <p><input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> Diastolic</p>	
<p>Screening Date</p> <input style="width: 20px; height: 20px;" type="text"/> (Month) <input style="width: 20px; height: 20px;" type="text"/> (Day) <input style="width: 40px; height: 20px;" type="text"/> (Year)			

****NOTE - LAB VALUES WILL NOT BE ACCEPTED IF COLLECTED PRIOR TO 11/1/2022.**

PROVIDER SIGNATURE

PROVIDER INSTRUCTIONS BELOW - READ CAREFULLY

Complete this section by checking the appropriate screening option. Provider signature and date required.

<p><input type="checkbox"/> Standard Health Screening</p> <p>I certify this patient has completed a standard health screening visit.</p>	<p><input type="checkbox"/> Preventive Visit</p> <p>I certify this patient has completed a preventive care visit (includes CDL physicals).</p>	<p><input type="checkbox"/> Exception</p> <p>I certify this patient should not complete the health screening as it is not medically necessary.</p>								
<p>Provider Signature: _____</p>										
<table style="border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr> <td style="text-align: center; font-size: small;">(Month)</td> <td style="text-align: center; font-size: small;">(Day)</td> <td colspan="2" style="text-align: center; font-size: small;">(Year)</td> </tr> </table>							(Month)	(Day)	(Year)	
(Month)	(Day)	(Year)								

SUBMISSION / QUESTIONS

Submit the completed fax form by **November 30, 2023**

- Fax: 1-877-657-4183
- Email: Saltchuk@vivacity.net

For questions regarding your health screening please contact Vivacity at
Saltchuk@vivacity.net

****NOTE - Emailing data is not considered a secure form of communication****

