Health Care Provider Form

Dear EngagementHealth Member:

Please have your health care provider complete this form and fax it to the number below. Once received by EngagementHealth, the information will be entered into your EngagementHealth Profile. ***Items marked with * are mandatory.*** *All data will remain confidential. Thank you!*

Dear Health Care Provider:

Your patient is a member of a company-sponsored wellness program from EngagementHealth. One component of this program is submitting annual biometric data. Please complete the information below based on a current or recent visit, and fax to us at the number below. All data will remain confidential.

We appreciate your assistance in making and keeping your patient healthy!

Patient Name:*		Date of Birth:*	/ /

Date of Test:*	/ /	Waist Circumference:		inches	
Height:*	inches	Weight:*		pounds	
BP Systolic:*		BP Diastolic:*		Pulse:*	bpm

Please document results from a ***fasting lipid panel*** *and/or* ***fasting glucose test*** *done within the* ***last 6 months*** *below:*

Date of Test:*	/ /	Fasting Blood Glucose:	
Total Cholesterol:*		HDL:*	
LDL:		Triglycerides:	

Signed (MD/NP/PA):_____

Print Name:_____

Address:_____

Phone:_____

Please complete and FAX this form to (312) 207-1863.