ANNUAL WELLNESS FORM

Return the completed form lshelby@nlr.ar.gov or mail to 300 Main ST, North Little Rock, AR 72119

EMPLOYEE INFORMATION The employee is the person employed by who is the primary enrollee in the health plan.

Last Name | First Name | Middle Initial | Date of Birth

PATIENT INFORMATION AND AUTHORIZATION The patient is the person receiving the exam. It may be the employee named above or the employee's spouse.

Last Name | First Name | Middle Initial | Date of Birth

Last 4 Digits of SSN | Gender | Select | Relationship to Employee (Self or Spouse)

Email Address

Patient Authorization: I have received the Notice regarding the confidentiality of this information and I understand that any information collected as part of the annual wellness program as applicable, including information collected such as medical preventive exams, health risk assessment, and biometric screening results, will be treated as confidential. Individual health information will not be shared with my employer, but my employer may receive aggregate information to assist in determining potentially beneficial programs to be offered in the future and information needed to administer the incentive payment. I also understand that this authorization is valid for a period of one year unless otherwise withdrawn. Please contact your employer for a copy of its Notice of Privacy Practices.

I understand that below information will be used in the following ways:

- By my provider as a means of informing me of my health risk and possible actions I can take to help me live a healthy life;
- To evaluate the impact of the wellness program;
- To provide my employer aggregate information as part of a group summary report and to administer the wellness program.

If I falsify any information, I understand I may be ineligible from any and all future Wellness Programs.

Patient Signature | Date

PROVIDER CERTIFICATION Please enter the date of the exam and complete each section based on the patient's current health status and care plans.

☐ If the patient should be exempt from one or more of these tests, please check this box and provide an explanation:

Provider Name | Provider NPI

Provider Phone # | Exam Date

I certify that this patient received a wellness exam as indicated by the tests shown on this form or is exempt from one or more test items as explained above.

Provider Signature | Date

ANNUAL WELLNESS FORM **Patient:** _____

EXAM INFORMATION Exam Date _____

Is the patient's systolic blood pressure within normal range? ☐ Yes ☐ No

Is the patient's diastolic blood pressure within the normal range? ☐ Yes ☐ No

Height: _____feet ____inches **Weight:** _____ lbs **BMI:** _____

Does this person have a diabetes-related diagnosis?

☐ No Diabetes Diagnosis ☐ Pre-Diabetes
☐ Type 1 Diabetes ☐ Type 2 Diabetes

Is the patient's cholesterol within normal range? ☐ Yes ☐ No

Does this patient use tobacco? ☐ Yes ☐ No

If tobacco products are being used, is the patient participating in any of the following tobacco cessation programs?

☐ Nicotine Replacement ☐ Medication Initiation
☐ Behavioral Counseling ☐ None

Has the patient been screened for depression or anxiety? ☐ Yes ☐ No

What is the patient's annual health goal?

☐ Diet ☐ Stress Management/Burnout
☐ Depression/Anxiety ☐ Self-Care
☐ Other:_____ ☐ None

If the patient is 21 years or older and has a cervix, are they up to date on cervical cancer screenings? ☐ Yes ☐ No

If the patient is 45 years or older, are they up to date on colon cancer screenings? ☐ Yes ☐ No

Screening type: ☐ Colonoscopy ☐ Cologuard ☐ FIT ☐ Other

If the patient is 40 years or older, did you have a discussion on whether a mammogram is appropriate? ☐ Yes ☐ No

If applicable, is this patient up to date on mammogram screenings? ☐ Yes ☐ No