WORTHINGTON
FAMILY MEDICAL &
WELLNESS CENTER

# WELLNESS PROGRAM
# PHYSICIAN FORM

1. Please PRINT CLEARLY.
2. You must have your doctor or doctor's office complete and sign this form.
3. Fax this form to WI Medical Center at (614) 840-3510.

First Name: _____ Last Name: _____

Date of Birth: _____ Employee ID/Clock Number: _____

Circle one: Male Female Circle one: Employee Spouse

BY SIGNING THIS FORM BELOW, I ATTEST THAT ALL OF THE ABOVE INFORMATION IS ACCURATE TO MY KNOWLEDGE.

Signature: _____ Phone:(___)_____

Date: _____

## PHYSICIAN OR OFFICE STAFF USE BELOW

Date Tested: _____ Fasting? Yes/ No Height: ft._____ in:____ Weight: lbs._____

| Blood Pressure Systolic | Blood Pressure Diastolic | HDL Cholesterol (lmg/dL) | Total Cholesterol (rg/dL) | LDL Cholesterol (rg/dL) | Triglycerides (mg/dL) | Total Cholesterol/ HDL Ratios | Glucose (mg/dL) |
|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

Office Name:_____
Physician Signature: _____
Facility City: _____ State:_____
Date:_____ Phone:(___)_____

Please fax the completed form to 614-840-3510