Annual Preventive Wellness Examination Form

2020 Randolph County Employee Wellness

This form is to be used by your Primary Care Provider (PCP) for your annual Exam.

Participant Information – To be completed by Employee (Please print clearly)

Participant's LEGAL name: _____

Please list your name as found on your social security card – no nicknames or hyphenated names.

Date of Birth (MM/DD/YYYY): ____ /____ /____ **Last four of social security number**: _____

Gender: Male Female

*Please note the above items are **required** for identification purposes.*

Phone Number:_____ Email: _____

Primary Care Provider: _____ Office Phone Number: _____

I agree to have my screening results shared with Wake Forest Baptist Health for purposes of the 2020 Wellness Program.

Participant's Signature:_____ Date Signed: _____

Shaded areas to be completed by Primary Care Provider (PCP).

ATTENTION Primary Care Provider: Please perform the following evaluations**.**

1. Lab Tests (**IMPORTANT:** ***Use diagnosis code Z00.00 for the following tests***)
   a. Total Cholesterol
   b. Total Cholesterol/HDL Ratio
   c. Hemoglobin A1c
2. Blood Pressure
3. Annual Preventive Wellness Examination – May include but not limited to medical history, vital signs, heart and lung exams, head, neck, and abdominal exams, neurological exam, skin exam and lab work.

Medical Practice Information

Name of Primary Care Provider: _____

Date of Visit (MM/DD/YYYY): _____/_____/_____ Clinical Staff Name: _____

Clinical staff signature: Date Signed:

Please bring this completed form to the WFBH onsite screening along with your printed labwork & blood pressure results as recorded by your PCP. You may print your labwork & blood pressure from your PCP portal. Handwritten results will not be accepted.