



PHYSICIAN RESULTS FORM

Take this form with you to your scheduled annual physical to be completed and signed by your primary care physician. It is the **participant's responsibility** to submit the Physician Results Form as part of the wellness program to be returned to Wellworks For You as outlined below, by **JULY 31, 2024**. Please retain a copy for your own records and submission to Wellworks For You, if necessary.

The form you are filling out will be scanned by a machine. To ensure that your data is uploaded accurately,

- Use a high-quality printer to print the form.
- Use black ink and fine-point pen.
- Please make sure that the text on the form is clear, aligned, and legible, preferably in block letters.
- Do not use fax or xerox copy. Do not fold or crease the form. **Check the form carefully before submitting.**

PATIENT CONTACT INFORMATION

COMPANY NAME: **K.L. BREEDEN & SONS LLC**

FIRST NAME: _____ LAST NAME: _____

DATE OF BIRTH: _____ MALE FEMALE

PHONE: _____ EMAIL: _____

SELECT ONE: I am the **Employee** **Spouse** *If spouse, please name employee:* _____

PHYSICIAN INFORMATION

PHYSICIAN OFFICE/NAME: _____

OFFICE PHONE/ADDRESS: _____

This **Results Form** confirms that the patient named above received the following preventive care between **MAY 1, 2023** and **JULY 31, 2024**. The primary care physician needs to complete the information below with an * in front of it and return the completed form to the patient named above.

| SCREENING | RESULTS |
|-----------------------------|---------|
| *Blood Pressure (Systolic) | |
| *Blood Pressure (Diastolic) | |
| *Height (in inches) | |
| *Waist Circumference | |
| *Weight (in pounds) | |
| BMI (Body Mass Index) | |

| SCREENING | RESULTS |
|---|---------|
| *Total Cholesterol | |
| *Low Density Lipoprotein (LDL) | |
| *High Density Lipoprotein (HDL) | |
| *Triglycerides | |
| *TC/HDL Ratio | |
| *Glucose (fasting) | |
| HbA1c (<i>if physician recommended</i>) | |
| Pulse (Heart Rate) | |

Physician

I certify that the patient listed above received the tests indicated on this form on: ____/____/____

Physician Signature: _____ Date Signed: _____

SUBMIT YOUR COMPLETED FORM BY JULY 31, 2024

All forms should be submitted to the Wellworks Forms Department. Submit your completed forms in one (1) of the following ways:

- **Upload to Portal:** Click the **Upload a Form** tile from the homepage or select **Get Started>Attach File** under My Next Steps and then select **Submit**.
- **Upload to Mobile App:** Tap the event that you are submitting a form for under the **Home** tab. On the following screen, tap the **Select Document** button to take or upload a photo of your form and then tap **Send My Forms**.

PLEASE NOTE: Wellworks For You requires at least seven (7) to ten (10) business days for processing and participation to be updated in the Wellness Portal.