Primary Care Provider Form

SMU EMPLOYEE INSTRUCTIONS

If you were not able to receive a Catapult Health Preventive Checkup this year, you may have your Primary Care Provider report lab and biometric values to receive credit toward the SMU wellness incentive being offered. All information requested below must be completed in order for credit to be awarded. Once complete, you must return your completed forms to Catapult Health by 5:00 pm on FRIDAY, APRIL 15, 2016. Please follow the instructions at the bottom of this page.
This is your responsibility, not your provider's.

PATIENT AUTHORIZATION AND RELEASE

With the understanding that my personal health information will only be shared as permitted and protected by law, I agree to the release of the information requested below from my Primary Care Provider to Catapult Health in order to complete requirements for my Company's wellness incentive. Catapult Health will securely store and may also disclose this medical information to me, to my physician(s), to my health plan, or a third party entity designated by my current or any future health plan or employer for use in health and disease management programs. I understand this information may be used to identify my health risks, to provide education regarding how to address my identified risks, and to possibly contact me to promote participation in health and disease management programs.

PLEASE PRINT CLEARLY. If illegible, your information will not be recorded.

PATIENT'S NAME: _____ **DATE:** ___/___/_____ **DATE OF BIRTH:** ___/___/_____
First M.I. Last Mo / Day / Year Mo / Day / Year

PATIENT'S SIGNATURE: _____ **PHONE NUMBER:** ( ) -

PATIENT'S E-MAIL: _____ **EMPLOYEE ID:** _____

ADDRESS: _____
Street or PO Box City State Zip

PROVIDER INSTRUCTIONS

SMU has partnered with Catapult Health to provide worksite wellness initiatives. Lab tests completed between March 7 and March 31, 2016 may be used to fulfill wellness incentive requirements. Please complete the information below and return this form to your patient.

Provider's Name		**Provider's Signature**	
Date of Tests		**Did patient fast?**	☐ YES ☐ NO
Total Cholesterol	mg/dL	**HDL Cholesterol**	mg/dL
Triglycerides	mg/dL	**LDL Cholesterol**	mg/dL
Glucose	mg/dL	**A1C** *(optional)*	%
Height	feet inches	**Weight**	lbs.
Abdominal Circumference	inches	**Blood Pressure**	/
Gender	☐ FEMALE ☐ MALE		

This completed form must be received by Catapult Health by 5:00 pm on APRIL 15, 2016

VIA MAIL: Catapult Health - PCP Form, 8144 Walnut Hill, Suite 1120, Dallas, TX 75231

VIA FAX: 877-885-9904 *(no cover page is needed)*

Primary Care Provider Form

Full Name: _____
Address: _____
_____
Date of Birth: _____
Company Name: _____

Today's Date: _____
Phone Number: _____
Email Address: _____
Gender: Male_____ Female_____
Employee_____ Spouse_____

Ethnicity: White_____ Black_____ Asian_____
American Indian or Native Hawaiian or Alaskan Native_____ other Pacific Islander_____

Do you consider yourself to be Hispanic or Latino? Yes_____ No_____

Health Questions	Please check your response below.
(If Female) Are you currently pregnant?	☐Yes ☐No ☐Not sure
Do you have a primary care physician or an OB/GYN who you see routinely for general health checkups?	☐ Yes ☐ No
When was the last time you had a medical checkup?	☐ < 3 months ☐ 3-12 months ☐ 1-3 years ☐ >3 years
When was the last time you had blood work done?	☐ < 3 months ☐ 3-12 months ☐ 1-3 years ☐ >3 years
Do you have an upcoming appointment scheduled with your primary care physician or OB/GYN?	☐ Yes, within the next 3 months ☐ Yes, in the next 3-12 months ☐ No, I don't have an appointment scheduled
Do you currently take any prescribed medications?	☐ Yes ☐ No
Do you currently take any over-the-counter medications, including decongestants or aspirin?	☐ Yes ☐ No
Do you have any allergies to any medications?	☐ Yes ☐ No
Are you allergic to fish or shellfish?	☐ Yes ☐ No
Do you currently take any vitamins or supplements, including fish oil or omega 3?	☐ Yes ☐ No
(If Female) Have you had a mammogram in the last year?	☐ Yes ☐ No ☐ N/A
(If Female) Have you had a PAP smear in the last year?	☐ Yes ☐ No ☐ N/A
(If Female) Have you had a breast exam performed by a healthcare provider in the last 3 yrs?	☐ Yes ☐ No ☐ N/A
(If Female) Have you had a breast exam performed by a healthcare provider in the last year?	☐ Yes ☐ No ☐ N/A
(If Female) Do you perform monthly self-breast exams?	☐ Yes ☐ No ☐ N/A
Have you had a colonoscopy or other colorectal cancer screening in the last year?	☐ Yes ☐ No
Have you had a flu vaccination in the last year?	☐ Yes ☐ No
Do you currently smoke tobacco?	☐ No, I have never smoked ☐ No, I quit smoking ☐ Yes, I currently smoke
Do you currently use any smokeless tobacco products, such as chewing tobacco or snuff?	☐ No, I have never used smokeless tobacco ☐ No, I quit ☐ Yes, I currently use smokeless tobacco
When is the last time you used tobacco?	☐ I quit within the last 6 months ☐ I have not used tobacco for more than 6 months ☐ I have never used tobacco
What are your intentions with respect to tobacco use?	☐ I have no intention of quitting ☐ I plan to quit within the next 6 months ☐ I plan to quit in the next month ☐ I do not currently use tobacco
(If Female) Do you have 3 or more alcoholic drinks on most nights each week?	☐ Yes ☐ No ☐ N/A
(If Male) Do you have 4 or more alcoholic drinks on most nights each week?	☐ Yes ☐ No ☐ N/A

Primary Care Provider Form

Full Name: _____

Health Questions (continued)	Please check your response below.
Are you currently taking medication for weight loss?	☐ Yes ☐ No
Do you eat a healthy diet with at least 2 cups of fruits and 3 cups of vegetables each day?	☐ Yes ☐ No
Which of the following statements about diet apply to you?	☐ I do not plan to change my eating habits in the next 6 months ☐ I am thinking about changing my diet within the next 6 months ☐ I am planning to change my diet in the next 30 days ☐ I began eating a healthy diet in the past 6 months ☐ I have been eating a healthy diet for more than 6 months
Do you obtain 150 minutes or more per week of moderate intensity exercise, or 75 minutes or more per week of vigorous exercise? Moderate intensity is equivalent to a brisk walk, whereas vigorous is a jog.	☐ Yes ☐ No
Which of the following statements about physical activity apply to you?	☐ I do not plan to engage in regular exercise in the next 6 months ☐ I am thinking about increasing my physical activity within the next 6 months ☐ I am planning to increase my physical activity in the next 30 days ☐ I began regular physical activity in the past 6 months ☐ I have been regularly exercising for more than 6 months
Have you ever been diagnosed with high blood pressure?	☐ Yes ☐ No
Have you ever been told you have pre-hypertension?	☐ Yes ☐ No
Are you currently taking medication to lower your blood pressure?	☐ Yes ☐ No
Have you ever been diagnosed with diabetes?	☐ Yes ☐ No
Have you ever been told you have pre-diabetes?	☐ Yes ☐ No
(If Female) Have you ever been diagnosed with diabetes with pregnancy?	☐ Yes ☐ No ☐ N/A
Are you currently taking medication or insulin for diabetes?	☐ Yes ☐ No
Has anyone in your immediate family (parents or sibling) been diagnosed with diabetes?	☐ Yes ☐ No
Have you ever had a heart attack, bypass or open heart surgery, or a stent implanted?	☐ Yes ☐ No
Have you been told by your doctor you have heart disease (e.g., coronary artery disease, cardiomyopathy, etc.)?	☐ Yes ☐ No
Have you ever been told your cholesterol is too high?	☐ Yes ☐ No
Are you currently taking medication to control your cholesterol?	☐ Yes ☐ No
Has anyone in your immediate family (parents or siblings) been diagnosed with early heart disease? (Male: age < 55, Female: age < 65)	☐ Yes ☐ No
Are you currently being treated for any thyroid problems?	☐ Yes ☐ No

Thank you for taking the time to complete this questionnaire!