Health Screening Form

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Dear Physician and/or Clinician,
The patient listed below is participating in an employer-sponsored health-management program administered by The McCahill Group, which includes submitting proof of an annual physical examination and a fasting biometric profile.

Employee: Please complete Section 1 of this form and have your provider complete sections 2 and 3 then submit to The McCahill Group via fax or mail by the 12/08/2024 deadline.

PLEASE NOTE: NONE OF YOUR PRIVATE PERSONAL HEALTH INFORMATION WILL BE SHARED WITH PAE.

The McCahill Group – 5510 Cascade SE, Suite #230 Grand Rapids, MI 49546
Phone – (616) 493-0476 | Fax – (888) 317-7599 | info@mccahillgroup.com

1. PATIENT INFORMATION (TO BE COMPLETED BY EMPLOYEE)

Patient's Name: _____ Male ☐ Female ☐ DOB: _____

Patient's Email Address: _____ Patient's phone number: _____

I authorize the clinician's office completing this form to release the information below to The McCahill Group.

Patient's signature: _____

2. TEST RESULTS (TO BE COMPLETED BY CLINICIAN) Biometrics must be completed within the last 12 months.

TEST	RESULT	Healthy Number Ranges*
☐ Fasting ☐ Non-fasting		BMI ≤ 27.5 kg/m2 (or) Waist Circumference Men ≤40 inches Women ≤ 35 inches (or) Reduce BMI by 1 point from prior year
Height (inches) _____	**Weight** (pounds) _____	
Body Mass Index (BMI)	_____ (nn.n format)	
Waist Circumference	_____ (inches)	
Total Cholesterol	_____ mg/dl	Total Cholesterol ≤ 200 (or) HDL Ratio Men ≤5.0 Women ≤ 4.0 (or) *Provider Initial Here:_____
HDL	_____ mg/dl	
HDL Ratio	_____ mg/dl	
Triglycerides	_____ mg/dl	
Blood Pressure	_____ mmHg	≤ 135 / 85 *Provider Initial Here: _____
Glucose	_____ mg/dl	≤ 126 *Provider Initial Here: _____
Tobacco User	☐ Yes ☐ No	Tobacco Free

***If results fall outside target range, member can agree to a treatment plan with provider.**

Note: If patient is pregnant, please write 'pregnant' in results box.

3. PHYSICIAN OR CLINICIAN SIGNATURE (FORM NOT VALID UNLESS SIGNED)

Date of testing/measurements: _____

Physicians Name: _____

Signature of Office Staff completing form: _____ **Date:** _____