Ambulatory Annual Enrollment Referral to Healthy Rewards

(If you are a SFHS Provider - PLEASE complete this in EPIC rather than using the paper copy - it will save you a lot of time)

Must be completed by a licensed health professional (MD, DO, NP, PA, APN) from a Primary Care Physician's office and emailed to **healthyrewards@sfmc.net** or faxed to **573-331-5056**. **PLEASE COMPLETE BOTH SIDES OF FORM.**

Patient Information:

Date of Examination: ___/___/_____

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: ___/___/_____ Employee or Spouse Employee's # _____

Phone: (____)_____ Email: _____

Biometric Data (Required):

Height: _____ Weight: _____ BMI: _____ Blood Pressure: _____/_____

Lab Work (Required):

Please check one of the following responses:

☐ All labs complete and listed below ☐ Labs will be CC'd to Healthy Rewards following completion
(cc to 573-331-5056 OR HealthyRewards@sfmc.net)

Date Drawn: _____ (must be within last 12 months)

Total Cholesterol: _____ LDL Cholesterol _____ HDL Cholesterol: _____ Triglyceride_____

Fasting Blood Sugar: _____ A1C: _____
(if Diabetic)

Chronic Conditions – Please complete each line

Check No if screen is negative or there is no patient history and Yes if the screen is positive by the definition listed or there is a patient history. If circling yes, circle the most accurate description below:

Hypertension (Yes if BP ≥ 140 and/or ≥90 OR taking medication to treat hypertension)

☐ YES ☐ NO

If yes: ☐ HTN history ☐ New diagnosis ☐ On medication

Diabetes (Yes if A1C ≥ 7.0 OR taking medication to treat diabetes)

☐ YES ☐ NO

If yes: ☐ Type I ☐ Type II ☐ On medication

Hyperlipidemia (Yes if LDL ≥160 OR Trig ≥200 OR taking medication to treat hyperlipidemia)

☐ YES ☐ NO

If yes: ☐ Hyperlipidemia history ☐ New diagnosis ☐ On medication

Please complete side 2 →

Overweight/Obesity (Yes if BMI ≥ 27 OR history of bariatric surgery)

☐ YES ☐ NO History of bariatric surgery? ☐ YES ☐ NO

If yes: Participants' BMI: _____

Participant is Not at risk because waist circumference is <= 33 inches for a female/ <= 37 inches for a male.

Waist Circumference: _____ inches

Currently pregnant?

☐ YES ☐ NO

Weeks Gestation: _____

Current Nicotine Use (Includes smoking, chewing, vaping and cessation aids)

☐ YES ☐ NO

I agree that if my patient's labs meet the chronic condition criteria listed above, they will be placed in the appropriate chronic track by the Wellness staff.

☐ YES ☐ NO

I authorize my patient to join the applicable physical activity and/or chronic condition program to help maintain or improve their health status.

☐ YES ☐ NO

Provider Information: (please print)

Last Name: _____ First Name: _____ Middle Initial: _____

Office Phone number: (____)_____ Provide Fax number: (____)_____

Provider Signature: _____

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