Employee Health Plan (EHP) Total Care
Health Visit Report Form

Must be completed by a licensed health professional (MD, DO, NP, PA) from your PCP's office and mailed or faxed directly to EHP Total Care

Date of Examination: ________________________

Provider Information:

Last Name: ____________________________ First Name: __________________ Middle Initial: ____

Office Address: ____

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Office Phone: (_____)______________________

Patient Information:

Last Name: ____________________________ First Name: __________________ Middle Initial: ____

EHP No.: ____________________ Date of Birth: ________________________

Biometric Data (Required):

Height: __________ Weight: _________ BMI: _________ Blood Pressure: ______ /______

Lab Work (Required):

Date Drawn: _________________________ (Must be within last 3 years)

Cholesterol Screening Result (Required only for age 40 or older): LDL: ______

Chronic Conditions — *Please complete each line*

(Check Y if patient has diagnosis; Check N if screen is negative or there is no patient history):

Hypertension:	Y____	N____	(Check Yes if BP >140/90 or on treatment regimen)
Diabetes:	Y____	N____	(If applicable, Type I or Type II: ____, goals for diabetes are BP <130/80, LDL <100)
Hyperlipidemia:	Y____	N____	(Check Yes if LDL >130 or on treatment regimen)
Asthma:	Y____	N____	
Overweight/Obese:	Y____	N____	(Check Yes if BMI is 27 or above)
Current Tobacco Use:	Y____	N____	

I authorize my patient to join the applicable physical activity and/or Coordinated Care Program to help maintain or improve their health status.

Provider Signature: ____

Please return by mail to:

Cleveland Clinic Employee Health Plan Total Care
29050 Aurora Road, SCC-13
Solon, OH 44139

or

e-mail to: **ehphc@ccf.org**

via fax: 216.448.9053

2014