eHealthScreenings
A Premise Health® company

Physician Screening Form
Screening Key: PHE138

Screening Name

Oklahoma County 2026 Health Screenings

Criteria and Instructions

The following testing criteria must be met for the participant to be eligible for the wellness program incentive.

1. The required fasting laboratory tests include: Lipid Panel and Fasting Glucose.
   - Optional laboratory tests include: HbA1c for all and PSA for Males 50+.
2. The required biometrics include: Blood Pressure, Height, Weight and Waist Circumference.
   - Optional biometrics include: Body Fat %.
3. **Blood results must be provided on this form and supported by a copy of your official lab results which includes your name, DOB, test results and test date for verification (a physician's letter will not suffice).**
4. All information included on this form is required. Any missing information may prevent or delay your results from being entered and could disqualify you from participating in the wellness program.
5. Do not provide a copy of this form to other participants. Each participant must request their own form.
6. Tests should be administered no earlier than: **8/1/2026** and no later than: **10/20/2026**.
7. Screening results must be received by eHealthScreenings no later than: **10/20/2026**.
8. Completed Physician Screening Form **and** supporting official laboratory form (a copy of your results) can be uploaded to your health screening portal. Go to Step 2 and select Upload Form. Alternatively, documentation can be emailed to ehs.physicianscreening@ehealthscreenings.com.

Section A | Participant Information *(participant to complete)*

First Name:	Last Name:
Legal Sex:	DOB: (mm/dd/yyyy): _____ / _____ / _____
Phone:	Email:

I agree and consent to the uses and disclosures of the information on the Notice and Authorization as provided with this form and/or during online registration.

Participant Signature (REQUIRED):	**Date:**

Section B | Physician and/or Testing Facility Information *(physician / nurse to complete)*

Physician & Practice / Facility Name:	
Address:	Phone #:
National Provider ID # or CLIA certification #:	Test Date (required): ____ / ____ / _____
Physician Signature:	**Date:**

Section C | Biometric Test Results and Fasting Status *(physician to complete)*

Blood Pressure

Systolic: (mmHg)	Diastolic: (mmHg)

Body Measurements (BMI is a calculated value and will be available in your final report from eHealthScreenings)

Height: (inches)	Weight: (lbs)	Waist: (inches)	Body Fat: (%)

Fasting Status

- ☐ Yes, I fasted 9 or more hours
- ☐ No, I did not fast 9 or more hours

Section D | Lab Test Results *(participant must fill in and submit both this form and lab report by the deadline)*

Blood Testing Results

Total Cholesterol: (mg/dl)	HDL Cholesterol: (mg/dl)	Triglycerides: (mg/dl)	Glucose: (mg/dl)	LDL Cholesterol: (mg/dl)	HbA1c: (mmol/mol)	PSA: (ng/mL)	

Please contact **eHealthScreenings** with any questions. Email us at help@ehealthscreenings.com or call **(888) 708-8807**. Fax (210) 767-2245.

Lab Report Must Be Attached

Health Screening Program Employee Notice and Authorization

Your employer has contracted with eHealthScreenings ("eHS") to provide certain health and/or wellness services in connection with voluntary health screening program.

Protection of Your Health Information: eHealthScreenings (eHS) abides by all applicable laws and regulations governing the privacy and security of your personal health information. We treat all individually identifiable health information as "protected health information" (PHI) under the Health Insurance Portability and Accountability Act and its implementing regulations (HIPAA) as a matter of best practice. The Member Information Privacy Practices is also available on the eHealthScreenings website via https://scheduler.ehealthscreenings.com/#/login. You may also request a copy at any time.

If applicable, by participating in the biometric screening, you consent to the collection of a blood specimen and/or bodily fluids. You understand and acknowledge that the collection of blood through a needle or fingerstick may cause pain, a bruise or, rarely, an infection. You also consent to the collection of additional biometrics (height, weight, blood pressure, waist circumference, and perhaps other measurements, as per the design of the program). You understand that a biometric screening is not meant to replace the care of a medical professional and that Premise Health may recommend that you seek additional medical care based on the screening.

By participating in the Program, the Health Screening Program may include the following types of visits: biometric screening, health risk assessment ("HRA"), flu vaccination, wellness or health coaching and outcome management check. By participating in the screening, you understand that certain health issues may be identified, such as high blood glucose, high cholesterol; however, this screening cannot and should not be considered a substitute for a thorough examination by, or testing recommended by, your personal physician. The screening data you receive is for informational use only and should not be considered diagnostic or conclusive.

Authorization: I acknowledge that joining the program is completely optional. To assess whether I qualify, the health screening program administrators must keep records of my participation. By signing below, I grant eHS permission to share details about my involvement with the program administrators. If the program needs to review my results, including measurements, tests, or blood samples, I also agree to let eHS provide these results to my employer, eHS Client, or any third party hired by my employer to analyze and review program results.

I understand that this information may be disclosed through electronic means. I also understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Effective Date: This consent and authorization will expire five (5) years from the date of signature.

Right to Revoke Authorization to Release PHI: I understand that I may revoke this authorization at any time by submitting notice of my revocation in writing to eHS, or Privacy@PremiseHealth.com. I understand that my revocation of this authorization does not affect any actions taken prior to receipt of my revocation. I further understand that my revocation of this authorization may impact my ability to participate in the incentive program and/or receive the incentives.

Signature and Copy: I have read this form in its entirety and voluntarily consent to the HRA collection and biometrics procedures. I agree and consent to the uses and disclosures of the information described above. I acknowledge that the person executing this form is the person participating in or receiving services, or such participant's legal representative who is authorized to act on such person's behalf to sign this form. I further acknowledge the participant is at least 18 years old. I understand that I have the right to receive a copy of this authorization upon request.