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PREVENTIVE CARE EXAM FORM

This form is for DIG employees who receive preventive care in **or** outside of the DIG Wellness Center.

Participant Name: _____ DOB: _____

If your physician does not recommend a particular screening due to a medical condition, please indicate below and have your physician sign. If you receive preventive care outside the DIG Wellness Center, after completion, please fax this form ***to Jennifer Flores, NP at the DIG Wellness Center 325-691-6385.*** All exams need to be completed and this form submitted **by January 1, 2020 or The Anniversary month of your last preventive exam**.

	Ages 40 and under		Ages 40-49		Ages 50 and over	
	Completion of the following:	**Date**	**Completion of the following:**	**Date**	**Completion of the following:**	**Date**
MEN	Full Blood Draw: Including Total Cholesterol, HDL, LDL, Triglycerides, and Blood Glucose		Full Blood Draw: Including Total Cholesterol, HDL, LDL, Triglycerides, and Blood Glucose		Full Blood Draw: Including Total Cholesterol, HDL, LDL, Triglycerides, and Blood Glucose	
	Blood Pressure Evaluation		Blood Pressure Evaluation		Blood Pressure Evaluation	
	Body Composition: Measures Height, Weight, Body Mass Index and Waist Measurement		Body Composition: Measures Height, Weight, Body Mass Index and Waist Measurement		Body Composition: Measures Height, Weight, Body Mass Index and Waist Measurement	
	Annual Physical		PSA Test		PSA Test	
					Colonoscopy*	
	Ages 40 and under		**Ages 40-49**		**Ages 50 and over**	
	Completion of the following:	**Date**	**Completion of the following:**	**Date**	**Completion of the following:**	**Date**
WOMEN	Full Blood Draw: Including Total Cholesterol, HDL, LDL, Triglycerides, and Blood Glucose		Full Blood Draw: Including Total Cholesterol, HDL, LDL, Triglycerides, and Blood Glucose		Full Blood Draw: Including Total Cholesterol, HDL, LDL, Triglycerides, and Blood Glucose	
	Blood Pressure Evaluation		Blood Pressure Evaluation		Blood Pressure Evaluation	
	Body Composition: Measures Height, Weight, Body Mass Index and Waist Measurement		Body Composition: Measures Height, Weight, Body Mass Index and Waist Measurement		Body Composition: Measures Height, Weight, Body Mass Index and Waist Measurement	
	Well Woman Exam Including Pap Smear		Well Woman Exam Including Pap Smear		Well Woman Exam Including Pap Smear	
			Mammogram		Mammogram	
					Colonoscopy *	

*While all of these tests can be performed annually, a colonoscopy is typically performed every 5 to 10 years beginning at age 50. It may be suggested more often based on personal/family health history, past results, or physician recommendations.

Please have your physician or nurse complete the information below. If applicable, please provide explanation of any exam listed above that is NOT recommended for this patient:

_____

_____

I confirm that the participant on the form has received the recommended preventive care for their age group listed above.

- ☐ The participant on the form is at risk or borderline for the health conditions tested and ____ is or ____is not following a prescribed treatment plan.
- ☐ The participant on the form meets the standards for each category tested.

Physicians Name (please print) _____ Date _____

Physician's Signature _____

Preventive Care Exam - health screening standards provided by the U.S. Department of Health and Human Services

Blood Pressure

Category	SPB mmHg		DBP mmHg
Normal *	<120	And	<80
Prehypertension	120-139	Or	80-89
Hypertension Stage 1	140-159	Or	90-99
Hypertension Stage 2	≥160	Or	≥100

Cholesterol- (after 9-12 hour fast)

LDL Cholesterol	
Optimal *	<100
Near Optimal *	100-129
Borderline High	130-159
High	160-189
Very High	≥190
HDL Cholesterol	
Low	<40
High	≥60

Total Cholesterol	
Desirable *	<200
Borderline High	200-239
High	≥240
Triglycerides	
Normal *	<150
Borderline High	150-199
High	200-499
Very High	≥500

Body Mass Index (BMI)

Underweight	<18.5
Normal Weight *	18.5-24.9
Overweight	25-29.9
Obesity (class 1)	30-34.9
Obesity (class 2)	35. 39.9
Extreme Obesity (class 3)	≥40

Glucose

	Fasting Glucose (mg/dL)
Diabetes	126 or above
Prediabetes	100 to 125
Normal *	99 or below

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Wellness Discount Certification Form

Please select the following that applies to you:

I have participated in a worksite wellness screening and as a result I discovered:

- ☐ I am currently at risk or borderline for the health conditions tested.
- ☐ I currently meet the standards for each category tested.

I select one of the following options regarding my steps forward:

- ☐ I choose not to participate in the DIG Wellness Initiative and forfeit the $50 monthly discount in health care coverage.
- ☐ I commit to participating in the DIG Wellness Initiative and attached is my action plan to reduce my health risk(s).
- ☐ I currently meet the required standards and attached is my plan to maintain my health status and prevent me from becoming at risk.

If you are a current smoker, select one of the following options regarding steps forward:

- ☐ I commit to quit using tobacco products and receive assistance from a smoking cessation program or by self-management.
- ☐ I use tobacco products and will continue to use tobacco products. I understand I will forfeit the $50 monthly discount in health care coverage and will be charged an additional $50 monthly surcharge.

If applicable, I have scheduled prescribed follow up appointment(s) with my physician. I will provide documentation of improvement in my identified risk(s).

Signature_____Date_____

ALL EMPLOYEES enrolling in medical coverage must complete this Affidavit

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Tobacco Status Certification
2020 Plan Year

In an effort to promote Health & Wellness for our employees, we are implementing a Tobacco User Surcharge for the remainder of the plan year.

If you smoke or use tobacco products (including, but not limited to, cigarettes, snuff, chewing tobacco, pipes, hookah or any other lighted smoking equipment) on a regular basis (daily/weekly consistently within the last 6 months), a **$50 per month surcharge** will apply.

If you are a tobacco user and complete a smoking cessation plan available through the DIG Wellness Center in the designated timeframe, we will refund the tobacco user surcharge, and discontinue any further tobacco user surcharge for the remainder of the plan year.

If you are not a smoker and do not use tobacco, you will not be assessed the surcharge.

Employees who do not timely return the Certification will automatically be defaulted to the tobacco user surcharge. This surcharge does not apply toward your spouse or dependent children.

Please contact Jennifer Flores, NP with the DIG Wellness Center if you have any questions.

Employee Name (Last, First, MI):	Department

Please check one option below:

- ☐ I smoke or use tobacco products on a regular basis. ***The $50 per month surcharge WILL apply.***
- ☐ I do not smoke or use tobacco products on a regular basis. ***The $50 per month surcharge WILL not apply.***

I agree to notify the DIG Wellness Center promptly at any time that I begin smoking or using tobacco products and understand that such use may cause the Tobacco User Surcharge to apply.

I further understand that knowingly falsifying this form or making any false statements or representation in connection with this form may result in the loss of health coverage and/or disciplinary action up to and including termination of employment.

Signature_____ Date_____

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*****ACTION PLAN*****

Action Plan Format:

Step 1: Health and fitness goals achieved during the current year based upon my previous action plan were…

Step 2: My health and fitness goals for the coming year are…

Step 3: This is my plan to maintain or reduce my current health risks:

Food: I commit to…

Exercise: I will…

Stress: I will reduce/keep my stress levels down by…

Print Name: _____

Sign: _____ Date:_____