2023-24 Primary Care Provider Follow Up Form

This form is ONLY used to provide documentation your PCP reviewed your labs – this will reward you with the first $200 towards your incentive. The remaining $200 incentive reward will depend on your submission of met goals either through your PCP or by scheduling rechecks with SPH Wellness Services.

- **This completed form must be faxed by your provider's medical office to St. Peter's Health Wellness Services at 447-2544 to receive the first $200 of the HSD Wellness Incentive. Cover sheet required to confirm validity.**
- **The form below indicates that because you did not meet all the required criteria that you have reviewed the results with your PCP and have discussed a plan to improve the values. Any improved values submitted by your PCP must be officially documented. We will not accept handwritten values due to the cash incentive behind meeting the requirements.**
- **If you met ALL criteria values – you do NOT need to submit this form or any other documentation.**

PATIENT INFORMATION

Patient's Last Name: _____ **Patient's First Name:** _____ **Gender:** _____

Patient's Phone #: ( ) - _____ **Patient's DOB:** / / **Date of Visit:** / /

Patient's Email: _____

No handwritten values – attach typed, charted values

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PROVIDER REVIEW

Provider Discretion – The below benchmarks are an agreement between St. Peter's Health Chief Medical Officer and Helena School District Wellness Committee. They do not reflect each provider's discretion for risk factors.

CRITERIA FOR HSD WELLNESS INCENTIVE	*CRITERIA GOALS – Deadline 6/28/2024*
Blood Pressure: ≤ 130/85 (values measured separately)	**Reduce adverse values by 5 points or into criteria range (values measured separately)**
Waist Circumference: Waist Circumference ≤ 40" (m) ≤ 35" (w)	**Reduce waist size by 2" or either into criteria range**
Cholesterol: ≤ 200 TC or Ratio ≤ 5 (m) ≤ 4.5 (w)	**Reduce TC by 10 or ratio by .5 points or into criteria range**
Fasting Blood Sugar: ≤ 110	**Reduce by 10 points or into criteria range**
Tobacco Status: Free of tobacco/nicotine for > 3 months	**Provide Certificate of Completion of a Tobacco Cessation program**

SIGNATURES

"By signing this form below, I certify as the patient's provider the blood screening results have been reviewed and for values that did not meet the criteria, I attest a discussion was had between myself and patient to manage the risk factors associated. The patient has also been advised to reassess with SPH Wellness to see if goals were met."

Patient Printed Name: _____ **Patient Signature:** _____

Provider Printed Name: _____ **Provider Signature:** _____

Provider Office Phone #: _____

NOTE: This form provides the first of two steps in receiving the full HSD Wellness Incentive. Patient must provide official medical documentation (office visit) of any goals met or return to SPH Wellness for rechecks. This second step will provide patient with the remainder of the incentive.