2024 Pregnancy and Postpartum Form

Instructions

1. Team members who are currently pregnant **or up to 12 months postpartum** may submit this form in place of a health screening. **Submissions outside the 12 month postpartum window will not be accepted.**

2. Complete the requested participant information and obtain your provider's signature.

3. Visit the Healthy Results wellness portal and submit under the Pregnant or Postpartum tile. Completed forms will only be accepted through this tile.

4. Approved submission types include Scan and Picture.

5. Accepted forms will receive 500 Healthy Results incentive points.

6. Team members can only receive points for one screening option per year (Onsite Screening, Provider Option Form, or Pregnancy/Postpartum Form). If you have already received points for one of these options, your Pregnancy/Postpartum Form will not be approved for points.

Participant Information

First Name:

Last Name:

Date of Birth (mm/dd/yyyy):

/ /

IU Health Email:

Due Date/Delivery Date (mm/dd/yyyy):

/ /

Provider Name:_____ Date :_____

Provider Signature:_____

Consent Information: This information along with any personal health information provided in completing the Health Survey is maintained in a secure area within the Wellness Department to be used only for calculating incentives for the Healthy Results program and is not shared with your immediate supervisor. Healthy Results will provide my employer aggregate information as part of a group summary report (individual data will not be disclosed.)

By submitting this form, I hereby consent to this use of my health screening information and grant any such wellness program associate permission to contact me regarding my results.

I understand that Healthy Results may utilize the above health information to track participation and provide me with health guidance. This information will be used to provide confidential services to me and to gather anonymous statistical data for my company. I understand that my basic statistics will be aggregated and presented in reports only to show trends in health conditions and use of services. No personal health information will be provided to my company. Biometric data or personal identifiers (i.e. date of birth, name, etc.) may be transferred to a 3rd party for reporting and/or incentive tracking.

I certify that the information supplied on this form has been provided to me by my health care provider, and Healthy Results may contact my provider regarding the information.

Participant Printed Name: _____

Participant Signature: _____ Date: _____