2024 Riley Children's Foundation Primary Care Provider Form

Indiana University Health

Instructions:

1. Complete all participant information, including email, and sign the form.
2. Visit your health care provider for a biometric screening and take this form.
3. Ask your provider to complete the Biometric Information section using results obtained **between 4/16/2024–8/14/2024** and sign the form.
4. Submit form once, using one method listed below. **Forms must be submitted by 8/14/2024.** Forms received after the deadline will not be accepted.
   a. **Preferred Method:** Securely upload online at https://www.totalwellnesshealth.com/gravity-landing/rcfpofupload/
   b. Fax securely to 402-881-8422.
   c. Mail to TotalWellness, Attn: Data Team, 9320 H Court, Omaha, NE 68127. Forms must be received **by 8/14/2024.** Please allow time for mailing.
5. Within 5 business days of form submission, a confirmation email will be sent to the email listed below. If a confirmation email is not received after 5 business days, please resubmit your form.

PARTICIPANT INFORMATION

Participant First Name: | Participant Last Name:

Participant Date of Birth: (mm/dd/yyyy) / / | Last 4 Digits of SSN: | Primary Phone Number: — —

Email: (Required to provide confirmation of form receipt.)

Gender:	O Male	O Female
Have you fasted for at least 9 hours? (*No food. Only water permitted.*)	O Yes	O No
Are you currently pregnant or up to 12 months postpartum?	O Yes	O No Delivery Date:__ / __ / ____
Within the last 6 months have you used any tobacco products?	O Yes	O No

BIOMETRIC SCREENING INFORMATION

Date of Screening: (mm/dd/yyyy) / /
(Acceptable Date Range: 4/16/2024 – 8/14/2024)

Blood Pressure: / (Diastolic)

Height: (Ft.) (Inches)

Weight: (Lbs.)

Waist: (Inches)

Glucose:

Total Cholesterol:

HDL :

LDL:

Tri:

HbA1C: .

Physician Printed Name:_____ Physician Phone Number:_____

Physician Signature:_____

CONSENT

Disclosure of Information. I understand that TotalWellness may utilize the above health information to track participation and provide health guidance. This information may be used to provide confidential services to me and 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 third party for reporting and/or incentive tracking.

GINA Notice and Authorization. This Screening is part of my employers wellness program ("Employer Program"), which is a voluntary wellness program administered according to federal rules, including the Genetic Information Nondiscrimination Act ("GINA"). The results of this Screening may be considered GINA Protected Information. GINA requires that you receive this GINA Notice and Authorization prior to undergoing the Screening. Your Employer Program uses GINA Protected Information to help you understand your potential health risks and to offer you other wellness program services. The Employer Program safeguards GINA protected information and will not disclose any GINA Protected Information, except as permitted by GINA and other applicable law. Your GINA Protected Information will be disclosed to you and to vendors of your Employer Program, for purposes of providing you with Employer Program services. Your GINA Protected Information will not be sold, exchanged or transferred, except to the extent required by law to carry out activities related to the Employer Program. You will not be asked to waive the confidentiality of this information as a condition of participating in the Employer Program or as a condition of receiving any incentive. Your GINA Protected Information will only be disclosed to your employer in aggregate terms that do not disclose your specific identity.

Certification: I certify that the information supplied on this form is accurate and has been provided to me by my health care provider and that TotalWellness may contact my provider regarding this information.

Participant Printed Name:_____ Date:_____

Participant Signature:_____

