Primary Care Provider Form

Fax this form AND medical visit documentation to: 447-2544

St. Peter's Health WELLNESS SERVICES

PARTICIPANT INSTRUCTIONS:

Share your screening results with your Primary Care Provider (PCP) and recheck screening benchmarks that did not meet criteria. Fax an official copy of a medical visit that lists the improved values for any adverse criteria values. You will be notified via email that we received the documentation. The medical visit must be dated **after** your LCC Wellness Screening. Remember, you can recheck all adverse values by scheduling an appointment with St. Peter's Wellness Services by calling 444-2128. You are welcome to hand deliver the medical visit documentation to our office.

***Documentation of goals met are due by October 15, 2021.**

PROVIDER INSTRUCTIONS:

Your patient is participating in the 2021 Lewis and Clark County Incentive that requires a wellness screening through St. Peter's Health Wellness Services. A reasonable alternative to any adverse values for cholesterol, fasting glucose, blood pressure, and weight associated with the patient's screening results can be submitted from your office. Improved values must be officially documented. **We will not accept handwritten values due to the incentive behind meeting the requirements.**

For your patient to remain compliant with this year's Wellness Incentive, please attach the copy of the office visit that shows the goal improvement for any one or more adverse criteria. Please see goal requirements below.

Screening Benchmarks	Criteria	Goals
Cholesterol	Total less than or equal to 200 or Ratio ≤ 5 (m) ≤ 4.5 (w)	Reduce total by 10 or ratio by 0.5 or into criteria range
Fasting Glucose	Fasting glucose ≤ 110	Reduce by 10 points or into criteria range
Waist Circumference	Waist Circumference ≤ 40 (m) ≤35 (w)	Reduce waist size by 2" or into criteria range
Blood Pressure	Less or equal to 135/85 (measurements used individually)	Reduce value by 5 points or into criteria range
Tobacco/Nicotine Status	Tobacco/Nicotine Free for at least 3 months	Complete Montana Quit Line program and submit certificate OR Freedom From Smoking

*** Provider's Name: _____ * Office Phone Number: _____**

PLEASE PRINT

*** Provider's Signature: _____**

PATIENT INFORMATION:

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

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

***Patients Email:** _____