

2020-2021 Physician's Screening Form



Diocese of Stockton and **TeamCare** want to help you reach your health goals. As part of your Wellness Program, you and your covered spouse (if applicable) can reduce your or your family's In Network medical deductible by completing this form, as well as the Health Risk Assessment, by **May 31, 2021**. *Your results are **100% confidential** and will not be shared with your employer.*

SECTION I: TO BE COMPLETED BY YOU (PLEASE PRINT)

Name: _____ DOB: _____ Gender: M / F
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Email: _____

SECTION II: TO BE COMPLETED BY YOUR PHYSICIAN

I have provided the above individual with an "Age Appropriate Physical", and have reviewed with them their current health status and made recommendations where appropriate.

Physician's Name (please print): _____ Date of Exam: _____

Physician's Signature: _____

Physician's Phone: _____ Physician's Fax: _____

SECTION III: BIOMETRIC DATA

Your annual physical must include a biometric screening. Your physician may include your results below or provide them to TeamCare via fax or email. Your results will be stored in the Wellness Portal for reference.

Date of Examination/Blood Work: _____

Fasting Non-Fasting

- Height: _____ feet _____ inches
- Weight: _____ pounds
- Waist Circumference: _____ inches
- Blood Pressure: _____ / _____ mm/Hg

- Total Cholesterol: _____ mg/dl
- HDL: _____
- LDL Cholesterol: _____
- Ratio Total/HDL: _____
- Triglycerides: _____
- Glucose Level: _____ mg/dl
- A1c _____
- Other: _____

All sections of this form are MANDATORY; incomplete forms will not be accepted. Please return your fully completed form to Delta TeamCare by MAIL, FAX or EMAIL NO LATER THAN MAY 31, 2021 to be eligible for the reduced deductible.

➤ **Mail:** Delta TeamCare

7110 Fresno St., Suite 350
Fresno, CA 93720

➤ **Fax:** 888-380-3415

➤ **Email:** teamcare@delapro.com

For questions please contact TeamCare at 866-724-0032...

