



Health Screening Form



Dear Physician and/or Clinician,

The patient listed below is participating in an employer-sponsored health-management program administered by The McCahill Group, which includes submitting proof of an annual physical examination and a fasting biometric profile.

Employee: Please complete Section 1 of this form and have your provider complete sections 2 and 3 then submit to The McCahill Group via fax or mail by the 10/31/2023 deadline.

PLEASE NOTE: NONE OF YOUR PRIVATE PERSONAL HEALTH INFORMATION WILL BE SHARED WITH PAE.

The McCahill Group – 5510 Cascade SE, Suite #230 Grand Rapids, MI 49546
Phone – (616) 493-0476 | Fax – (888) 317-7599 | info@mccahillgroup.com

1. PATIENT INFORMATION (TO BE COMPLETED BY EMPLOYEE)

Patient's Name: _____ Male Female DOB: _____

Patient's Email Address: _____ Patient's phone number: _____

I authorize the clinician's office completing this form to release the information below to The McCahill Group.

Patient's signature: _____

2. TEST RESULTS (TO BE COMPLETED BY CLINICIAN) *Biometrics must be completed between 11/1/2022 and 10/31/2023

TEST		RESULT	Healthy Number Ranges*
<input type="checkbox"/> Fasting <input type="checkbox"/> Non-fasting			BMI \leq 27.5 kg/m ² (or) Waist Circumference Men \leq 40 inches Women \leq 35 inches (or) Reduce BMI by 1 point from prior year
Height (inches) _____	Weight (pounds) _____		
Body Mass Index (BMI)	_____ (nn.n format)		
Waist Circumference	_____ (inches)		
Total Cholesterol	_____ mg/dl		Total Cholesterol \leq 200 (or) HDL Ratio Men \leq 5.0 Women \leq 4.0 (or) *Provider Initial Here: _____
HDL	_____ mg/dl		
HDL Ratio	_____ mg/dl		
Triglycerides	_____ mg/dl		
Blood Pressure	_____ mmHg		\leq 135 / 85 *Provider Initial Here: _____
Glucose	_____ mg/dl		\leq 126 *Provider Initial Here: _____
Tobacco User	<input type="checkbox"/> Yes <input type="checkbox"/> No		Tobacco Free

*If results fall outside target range, member can agree to a treatment plan with provider.

Note: If patient is pregnant, please write 'pregnant' in results box.

3. PHYSICIAN OR CLINICIAN SIGNATURE (FORM NOT VALID UNLESS SIGNED)

Date of testing/measurements: _____

Physicians Name: _____

Signature of Office Staff completing form: _____ Date: _____