



**Cleveland Clinic/Akron General
Employee Health Plans (EHP)
Health Visit Report Form**

Must be completed by a licensed health professional (MD, DO, NP, PA)
from your PCP's office and mailed or faxed directly to EHP

Date of Examination: _____

Provider Information:

Last Name: _____ First Name: _____ Middle Initial: _____

Office Address: _____

Office Phone: (_____) _____

Patient Information:

Last Name: _____ First Name: _____ Middle Initial: _____

EHP No.: _____ Date of Birth: _____

Biometric Data (Required):

Height: _____ Weight: _____ BMI: _____ Blood Pressure: _____ / _____

Lab Work (Required):

Date Drawn: _____ (Must be within last 3 years)

Cholesterol Screening Result (Required only for age 40 or older): LDL: _____

If under age 40, all individuals should have a baseline panel. If normal, repeat at age 40.

Chronic Conditions — Please complete each line

(Check Y if patient has diagnosis; Check N if screen is negative or there is no patient history):

Hypertension: Y___ N___ (Check Yes if BP >140/90 or on treatment regimen)

Diabetes: Y___ N___ (If applicable, Type I or Type II: _____,
goals for diabetes are BP <130/80, LDL <100)

Hyperlipidemia: Y___ N___ (Check Yes if LDL >130 or on treatment regimen)

Asthma: Y___ N___

Overweight/Obese: Y___ N___ (Check Yes if BMI is 27 or above)

Current Tobacco Use: Y___ N___

I authorize my patient to join the applicable physical activity and/or Coordinated Care Program to help maintain or improve their health status.

Provider Signature: _____

Please return by mail to:

Cleveland Clinic/Akron General Employee Health Plans
3050 Science Park Drive / AC332B
Beachwood, OH 44122

e-mail to: ehphc@ccf.org
or
via fax: 216.448.2053