



**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 (Required):**

Last name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Office Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Office Phone: (    ) \_\_\_\_\_

**Patient Information (Required):**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

EHP ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Biometric Data (Required):**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_/\_\_\_\_\_

**Lab Work (Required):**

If under age 40, all individuals should have a baseline panel. If normal, repeat at age 40.  
For age 40 or older, cholesterol screening must be within last three years.

Date Drawn: \_\_\_\_\_ LDL: \_\_\_\_\_

**Chronic Conditions (Required) - 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 1 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 Nicotine Use Y\_\_\_\_\_ N\_\_\_\_\_ (Includes smoking, chewing and vaping)

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- (Required):** \_\_\_\_\_

**Please return by mail to:**

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

**email to:** ehphc@ccf.org

or

**via fax:** 216.448.2053

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