HealthyChoice

Cleveland Clinic
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 (Required): _____

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 Employee Health Plan
25900 Science Park Dr. / AC242
Beachwood, OH 44122

email to: ehphc@ccf.org
or
via fax: 216.448.2053

1/2023