Cleveland Clinic

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 ID: _____ Date of Birth: _____

Biometric Data:
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 indivdiuals 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 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: _____

Please return by mail to:
Cleveland Clinic/Akron General Employee Health Plans
3050 Science Part Drive / AC332B
Beachwood, OH 44122

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