BUTLER ADVANTAGE
HEALTH & WELLNESS CENTER
in partnership with CareHere!

NON-CAREHERE PROVIDER BLOOD WORK FORM

BUTLER Health Plan Wellness
butlerhealthplan.org Supporting Healthy Lifestyles

Participant Instructions:

If you choose to utilize a provider outside of the Butler Advantage Health & Wellness Center and/or on-site AHA events to earn the wellness credit, the following steps must be completed by 10/15/21.

Step 1: Schedule/complete a lab draw appointment with your Primary Care Provider (PCP) **before 10/15/21**.

- PCP must completely fill out the form
- Blood work results must include 21 of 28 labs (see below) and those with an asterisk (*)
- Blood work after **1/1/21** counts for the wellness credit

Note: You may incur a charge for lab work performed by your PCP. As a reminder, these services are provided FREE at the AHA screening events or at the Butler Advantage Health & Wellness Centers.

Step 2: The completed form and copy of lab results must be returned by **by 10/15/21** via FAX 513.896.2399 (Attn: Butler Advantage Health & Wellness Center) **OR** directly to:

- Beavercreek (937.458.2588): 3040 Kemp Road | Suite 100 | Beavercreek, Ohio 45431
- Hamilton (513.896.2398): 400 N Erie Blvd | Suite D | Hamilton, Ohio 45011
- Sharonville (513.896.2398): 301 Scarlet Oaks Drive | Sharonville, Ohio 45241

NOTE: If your blood work is not completed in the specified time frame, if your forms are not completed in full by your PCP, and if the forms and labs are not received by the Butler Advantage Health & Wellness Center by the specified date, you will not receive the wellness credit.

Please print clearly in **CAPITAL LETTERS** and fill out each blank space area using an **ink pen (*required).**

PROVIDER REQUIRED DOCUMENTATION - ALL FIELDS ARE REQUIRED*

***Patient's Last Name:** ______________________ ***Patient's First Name:** ____________________ ***Gender:** ______

***Patient's Phone #:** (____) _____- _____ ***Patient's DOB:** / / ***Date of Visit:** / /

***Height:** _______ **feet** ______ **inches** ***Weight:** _________ **pounds** ***BMI:** _______

***Blood Pressure:** ______ / ______ ***Waist Circumference (at navel level):** ______ **inches**

***Patient cleared for exercise?** ☐ **YES** ☐ **NO**

***Blood Panel -** MUST INCLUDE **21** of 28 labs (below) and must include **Total Cholesterol and Fasting Blood Sugar**.
A copy of blood work must be included with this form in order to be eligible for the incentive.

☐ ***Total Cholesterol**	☐ Chloride (Cl)	☐ Phosphorus, Serum	☐ Lactate Dehydrogenase Enzyme
☐ LDL Cholesterol	☐ Carbon Dioxide (CO2)	☐ Magnesium, Serum	☐ Albumin, Serum
☐ ***HDL Cholesterol**	☐ Blood Urea Nitrogen (BUN)	☐ Aspartate Aminotransferase Enzyme	☐ Protein, Total, Serum
☐ T. Chol/HDL Ratio	☐ Creatinine (Creat)	☐ Alanine Aminotransferase Enzyme	☐ Globulin, Total
☐ Triglycerides	☐ BUN/Creatinine Ratio	☐ Gamma Glutamyl Transferase Enzyme	☐ Prostate Specific Antigen, Serum
☐ Sodium, Serum	☐ ***Glucose, Serum**	☐ Bilirubin, Total	☐ Iron, Serum
☐ Potassium, Serum	☐ Calcium (Ca)	☐ Alkaline Phosphatase, Serum	☐ Uric Acid, Serum

Signatures:

Provider's Name: (print) ______________________________ Provider's Signature: ____________________________

Office Phone: __________________________________ UPIN/NPI: ___________________________________

PATIENT SIGNATURE REQUIRED FOR PROGRAM PARTICIPATION
By signing, I authorize the disclosure of my health screening results to be uploaded to my CareHere Medical Record.
All information released will be protected in accordance with any applicable law.

Patient's name: (print) ______________________________ Patient's Signature: ____________________________

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