Cleveland Clinic

Employee Health Plan (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 Employee Health Plan
3050 Science Park Drive / AC332B
Beachwood, OH 44122

or

e-mail to: **ehphc@ccf.org**

via fax: 216.448.2053

8/2015