HSD 2024-25 Primary Care Provider Follow Up Form

- To receive the first $200 of the HSD Wellness Incentive, this completed form must be faxed by your provider's medical office to St. Peter's Health Wellness Services at **406-447-2544**.
  DUE BY JUNE 30, 2025.
- This form indicates that you have reviewed your results with your PCP and have discussed a plan to improve values for the required criteria. Any improved values submitted by your PCP must be officially documented. **We will not accept handwritten values due to the cash incentive behind meeting the requirements.**
- If you met ALL criteria values – you do NOT need to submit this form or any other documentation.

PATIENT INFORMATION

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

Patient's Phone #: ____________________ **Patient's DOB:** ___________ **Date of Visit:** _____________

Patient's Email: ____

PROVIDER REVIEW

CRITERIA FOR HSD WELLNESS INCENTIVE	*CRITERIA GOALS – Deadline 6/30/2025*
Blood Pressure: ≤ 130/85 (values measured separately)	Reduce adverse values by 5 points or into criteria range (values measured separately)
Waist Circumference: Waist Circumference ≤ 40" (m) ≤ 35" (w)	Reduce waist size by 2" or either into criteria range, Complete Lifestyle Wellness Program
Cholesterol: ≤ 200 TC or Ratio ≤ 5 (m) ≤ 4.5 (w)	Reduce TC by 10 or ratio by .5 points or into criteria range
Fasting Blood Sugar: ≤ 110	Reduce by 10 points or into criteria range
Tobacco Status: Free of tobacco/nicotine for > 3 months	Provide Certificate of Completion of a Tobacco Cessation Program or Complete Attestation Form

SIGNATURES

"By signing below, I certify as the patient's provider the screening results have been reviewed and for values that did not meet the criteria, I attest a discussion was had between myself and patient to manage the risk factors associated. The patient has also been advised to reassess with SPH Wellness to see if goals were met."

Patient Printed Name: ________________________________ **Patient Signature:** ___________________________

Provider Printed Name: _______________________________ **Provider Signature:** __________________________

Provider Office Phone #: ____

St. Peter's Wellness Services
wellness@sphealth.org
Phone: 406-444-2128
Fax: 406-447-2544

No handwritten values – attach typed, charted values

No handwritten values – attach typed, charted values