Wellness Warriors | University Pharmacy at Wayne State | Ulliance

Health Screening Provider Use Only
☐ HTN ☐ MTM
HRA Complete ☐ Yes ☐ No

IMPORTANT NOTICE: Please provide your WSU OneCard when you present this form.

First Name: _____
Last Name: _____
Access ID: _____ Banner ID: _____
Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Preferred Contact Phone Number: (_____) _____
May we leave you a message at this number? ☐ Yes ☐ No

Preferred Contact Email: _____
May we send result information to this email address? ☐ Yes ☐ No

Please list the prescription medications you currently take:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Please list the over-the-counter medications/supplements you take:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Do you smoke? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No
Do you have dietary restrictions? ☐ Yes ☐ No
Do you exercise regularly? ☐ Yes ☐ No
Have you taken the online Health Risk Appraisal? ☐ Yes ☐ No
Have you had any food or drink, except water, in the last 9-12 hours? ☐ Yes ☐ No
Has anyone in your immediate family (mother, father, sibling) had cardiovascular disease (heart attack or stroke) ☐ Yes ☐ No
If yes, who and at what age? _____

Please check all the conditions that apply to you:

☐ High Blood Pressure ☐ Stroke ☐ Coronary Disease
☐ High Cholesterol ☐ Diabetes ☐ Bypass Surgery
☐ Angioplasty ☐ Kidney Disease ☐ Angina (chest pain)
☐ Peripheral Artery Disease ☐ Heart Attack

TESTING CONSENT

I am requesting to receive a biometric health screening to be administered by the appropriate personnel designated by University Pharmacy and Wayne State University College of Pharmacy and Health Sciences. I hereby consent to the administration of the test to me. In signing this consent, I verify the following:

- I have read and understand all the terms of this consent. I agree to all of its terms and execute it to my own free will.
- I have chosen, of my own free will, to receive and participate in the test.
- I have received a copy of and understand the University Pharmacy Notice of Privacy Practices.

I understand and agree that this test and the results therefrom are not meant to be a substitution for consultation with or advice from my physician. I understand that I may receive results that may be considered "abnormal" as well as an explanation of these results. However, I also understand that screening tests can give false positive or negative results for a variety of reasons. I further understand and agree that it is my obligation to arrange a follow-up consultation with my physician to review the test results and discuss the appropriate course of action.

I hereby release University Pharmacy, Wayne State University and Wayne State University College of Pharmacy and Health Sciences, Ulliance and their representatives and agents from and against any and all liability for damages or injuries resulting from my failure to follow-up with my physician regarding the test results.

RESULTS

Ht. _____ ft. _____ in.
Wt: _____ lbs. BMI: _____
Waist: _____in.
BP: Systolic: _____
Diastolic: _____
10-yr Risk Score: _____

Patient Signature: _____
Date: _____/_____/20_____

Your Initial Ulliance Wellness Coaching Session - Date:_____/_____/_____ Time: _____
Call 1-**888-699-3554** to schedule Wellness Coaching To complete and/or view your HRA:
http://www.welliance.com/ wsu/wsu_services.htm