MY HEALTHY BLUEPRINT
2021 WELLNESS VISIT

PROVIDER TO FAX TO: 850.908.9030

PATIENT DEMOGRAPHICS TO BE COMPLETED BY PATIENT: *(All Fields Required)*

Legal First Name:______________________ Last Name:______________________ Date of birth: ____________

Mailing Address: ________________________________City:________________ State/ZIP:______________

Phone:______________________________ Email Address: ____________________________________

Employee ID or name of BHC/LCI employee who carries the health insurance: ______________________________

INFORMATION BELOW MUST BE COMPLETED BY MEDICAL PROVIDER:

How was this visit completed? ❑ in person ❑ via Telehealth

*If completed via Telehealth, fields with * may be omitted.*

Height (w/o shoes):*	Weight (w/o shoes):*	BMI:*	Blood Pressure:*

Place a check in the box that best describes the current health status of this patient. ONLY CHECK ONE.	
	Patient is healthy, with no significant risk factors.
	Patient is healthy, but at risk for a chronic disease or has other significant risk factors.
	Patient has one or more chronic diseases with significant risk factors, but is stable or at desired treatment goal.
	Patient has one or more chronic diseases with significant risk factors, and is not at desired treatment goal.
	Patient has multiple chronic diseases, significant risk factors, complications and/or complex treatment(s).
	Patient has complex condition in which his/her health may or may not be restored.

List top three treatment goals for this patient:

1. ______________________________
2. ______________________________
3. ______________________________

Additional comments:

Pharmacotherapy Clinic is a pharmacist managed clinic that works closely with patients and their health care providers in managing medications. The purpose is to reduce adverse effects, reduce avoidable hospital readmissions, provide ongoing education and ensure best outcome for patients. This service is free for those insured by Baptist Health Care.

Provider, please initial if you **do not** want your patient utilizing this service. ____

Physician's Printed Name: ______________________ Physician's Signature: ______________________

Physician's Office Number: ______________________ Date of Visit: ______________________

This form must be completed by a primary care provider as part of a wellness exam. Urgent care, CVS MinuteClinic and other like clinics will not be accepted. Women under the care of an OBGYN during pregnancy may have OBGYN complete the form.

850.469.6903
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