Cleveland Clinic

Employee Health Plan (EHP) Total Care Health Visit Report

Must be completed by a licensed health professional (MD, DO, NP, PA)
and mailed or faxed directly to the EHP Total Care

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: _____

Cholesterol Screening Result **age 40 or older**: LDL: _____

Chronic Disease List — ***Please complete all sections***

(Check Y if patient has diagnosis, check N if screen is negative or there is no patient history):

Hypertension: Y____ N____

Diabetes: Y____ N____ (If applicable, Type I or Type II: ____)

Hyperlipidemia: Y____ N____

Asthma: Y____ N____

Overweight/Obese: Y____ N____ (If BMI is above 27.0 please check yes)

Current Tobacco Use: Y____ N____

Provider Signature: _____

Please return by mail to:

Cleveland Clinic Employee Health Plan Total Care
29050 Aurora Road, SCC-13
Solon, OH 44139

or

e-mail to: ehphc@ccf.org

via fax: 216-448-9053