SOUNDHEALTH CONNECTS

# Eligibility Verification Form *to be filled out by Physician or Health Care Provider*

Patient Name: _____ Date: _____
Last First M.I.

Patient DOB: _____(mm/dd/yyyy)

Patient's Weight _____ Patient's Height _____ Patient's BMI _____

Patient's Pulse _____ Patient's Blood Pressure _____/_____

## The patient currently has the following conditions:

- ❒ Anxiety
- ❒ Arthritis
- ❒ Asthma
- ❒ Congestive Heart Failure
- ❒ Coronary Artery Disease
- ❒ Depression
- ❒ Diabetes, Type I
- ❒ Diabetes, Type II
- ❒ Fatigue
- ❒ GERD
- ❒ Hyperlipidemia
- ❒ Hypertension
- ❒ Hypothyroidism
- ❒ Low Back Pain
- ❒ Polycystic Ovarian
- ❒ Sleep Apnea
- ❒ Other: _____

## Lab Work *(required)*

*Any additional evaluation, i.e., cardiac evaluation prior to beginning an exercise program, TSH, etc., should be performed at the discretion of the primary care provider.*

HDL _____ LDL _____ Triglycerides _____ Total Cholesterol _____

BP_____ Body Fat %_____ Glucose _____ Liver Function Test _____

**Provider Name** _____

**Provider Signature** _____

**Provider Fax:** _____

**Provider Phone:** _____

****Physician's Office: Please fax this form to Sound Health Connects at (206) 962-3155****

**Corporate:**
Seattle, Washington
P: 866-779-4730
F: 206-962-3155
www.soundhealthconnects.com

# PHYSICIAN OR HEALTH CARE PROVIDER CONSENT

Once signed, please fax to Sound Health Connects at (206) 962-3155

Your patient has expressed an interest in enrolling in Sound Health Connects weight and health-risk management program. Sound Health Connects delivers comprehensive telephone and web-based programs that include certified personal training, nutrition and behavior change designed to help individuals develop healthy habits around eating and exercise.

If your assessment of your patient shows that he/she is able to participate in this program, Please sign below and fax this form to (206) 962-3155. Should there be any specific instructions and or contra-indications regarding this patient's care, please attach a note or report to this consent form.

Based on my clinical assessment of patient,_____,

I feel that he/she is an appropriate candidate for entry into a Sound Heath Connects program. I understand that Sound Health Connects programs include the following components:

- Exercise (both under the supervision of a personal trainer and independent of supervision)
- Nutrition counseling
- Behavior-change counseling

_____

Physician/Health Care Provider Name (please print)

_____

Signature Date

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