PRIMARY CARE PROVIDER (PCP) FORM

SECTION 1 TO BE COMPLETED BY LEPRINO FOODS EMPLOYEE

Write your name exactly the way that it appears on your paycheck. This form must be returned before **December 31, 2024**. *Complete all required fields.

*First Name:		*Last Name:	
*Employee ID:		*Phone #:	
*Leprino Plant Location (City):			
*Employee Email:			
*Date of Birth:			
*Appointment Date:			
PCP Email:			

SECTION 2 TO BE COMPLETED BY PRIMARY CARE PROVIDER (PCP)

NOTE: Test values shown below must be COMPLETED AND FAXED by Primary Care Provider (PCP)

Please record data for each field listed. Forms with missing information will not be processed.

TEST	RESULTS	NOTES
Pregnant	☐ Yes ☐ No ☐ N/A	*If pregnant, HealthYou only requires blood pressure and blood glucose testing.*
Height	Feet Inches	
Weight (pounds)		
Waist Circumference		← **Waist Circumference MUST BE COMPLETED.**
Body Mass Index (BMI)		
Blood Pressure (BP)		
Blood Glucose		Fasting? ☐ Yes ☐ No
HDL Cholesterol		
LDL Cholesterol		
Triglycerides		
Total Cholesterol (TC)		
TC/HDL Risk Ratio		
Tobacco Use	☐ Yes ☐ No	

Fax form to: HealthYou at: 1-844-549-6620

PCP Printed Name:		Phone #:	
PCP Signature:		PCP ID (NPI#):	