



Physician Screening Form

*** If you have attended an onsite screening, DO NOT submit this PSF form ***

Please print clearly. Items marked with asterisk * are required.

Incomplete or illegible forms will not be processed.

Choose only ONE of the following submission options: 1) Upload Online: <https://livewell.preventure.com> 2) Fax: 855-385-5453

3) Mail to: Preventure | Customer Solutions Department | 2000 Nooseneck Hill Road | Coventry, RI 02816

SECTION 1 - Personal Information (Participant/Patient Completes)

Participant/Patient First Name * **DANA** M.I. Participant/Patient Last Name * **MOOLANT**

Employee First Name (if different from Participant/Patient) * M.I. Employee Last Name *

Employee's Company Name **OAK TREE** Username * (see form instruction sheet for your Username format) **Levy01**


Date of Birth * **05/11/1980** Primary Phone * **202/2762191** Secondary Phone

Email Address (Required to receive an email confirmation of receipt of your form)

danamilevy@gmail.com

Gender * ☒ Male ☐ Female If female, are you currently pregnant? * ☐ Yes ☒ No Participant Status * ☒ I am the Employee

By signing below, I acknowledge the Wellness Program Notice and Consent.

Participant/Patient Signature *  Date * **12/04/2018**

SECTION 2 - Clinical Information (Physician or Health Care Provider's Office completes – report only the tests required)

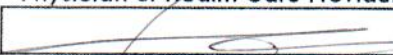
Date of Lab Work * **02/06/2018** Height (total in inches) * **5'2"** Weight (pounds) * **107**

Biometric Measurements Required Values Marked *	Patient Results
Waist Circumference *	25
Body Mass Index-BMI *	19.6
Blood Pressure (Systolic/Diastolic) *	110/80
Glucose (mg/dl) *	94
Total Cholesterol *	175
HDL Cholesterol (mg/dl) *	59
LDL Cholesterol (mg/dl) *	98
Cholesterol/HDL Ratio *	3.0
Triglycerides (mg/dl) *	92

Dr. Marina Gafanovich
1550 York Avenue New York NY 10028
(212)249-6218
License #236435

SECTION 3 - Physician Information (Physician or Health Care Provider's Office Completes)

Physician or Health Care Provider's Name (please print clearly) * **GAFANOVICH** National Provider Identifier (NPI) if applicable **1942328802**

Office Phone Number * **212/249/6218** Date * **12/07/2018** Physician or Health Care Provider's Signature * 

The information you are submitting may be shared with a third party for the sole purpose of administering additional wellness program services or to conduct other wellness programming activities as permitted by law and will comply with applicable law. Preventure will maintain the confidentiality of your personally identifiable information and will only release personal information as permitted by law for the sole purpose of wellness program administration.

Copyright © Preventure-All rights reserved. No portion of this material may be copied or reproduced without prior written permission.