BAPTIST HEALTH
HEALTHIER TOGETHER

Baptist Express Care Clinics

The following Baptist Express Care Clinics are available in your region. As participants in the Baptist Health Healthier You! program, you may choose to visit one of these clinics to have your biometric screening performed. Please take this "Partner Clinic Kit" to your local Baptist Express Care location for your health screening.

Baptist Express Care Locations

Located within select Walmart Super Centers

Louisville	Address	Phone Number
Louisville Hillview	11901 Standiford Plaza Drive, 40229	502-969-0526
Louisville Outer Loop	175 Outer Loop, 40214	502-855-6675
La Grange	1015 New Moody Lane, 40031	502-991-0589

Lexington	Address	Phone Number
Lexington Hamburg	2350 Grey Lag Way, 40509	859-263-3822
Lexington North Park	500 West New Circle Road, 40511	859-967-0964

Bluegrass Region	Address	Phone Number
Nicholasville	1024 North Main Street, 40356	859-241-2148
Danville	100 Walton Avenue, 40422	859-236-4224
Somerset	177 Washington Drive, 42503	606-678-2880
Winchester	1859 ByPass Road, 40391	859-355-1882
Paris	305 Letton Drive, 40361	859-522-0001
Berea	120 Jill Drive, 40403	859-985-7195

Southeastern Region	Address	Phone Number
Corbin	60 South Stewart Road, 40701	606-528-9770
Williamsburg	589 West Highway 92, 40769	606-549-5154

Paducah	Address	Phone Number
Paducah Hinkleville	5130 Hinkleville Road, 42001	270-450-1191
Paducah Southside	3220 Irvin Cobb Drive, 42003	270-450-1240
Madisonville	1756 East Center Street, 42431	270-821-3300
Hopkinsville	300 Clinic Drive, 42240	270-707-4262

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PARTICIPANT INSTRUCTIONS

1) ***Your screening will be performed by a Baptist Express Care Clinic.***
While some clinics perform screens on a walk-in basis, it is important that you contact the selected clinic to determine if an appointment is required.

2) ***Go to a Baptist Express Care Clinic for Health Assessment / Screening and complete the consent form.***
Please complete the consent form given to you at the Baptist Express Care and provide all the requested information, as this will allow Baptist Health Employer Solutions to ensure that you receive your lab results. Also, please remember to sign and date the consent form in the space provided.

Preparations for your exam:

- **Fast from food starting 8 – 12 hours before your screen time** (you may drink only water, and one 8 oz. cup of black coffee is allowed)
- **Drink plenty of water the night before or the morning of the screening as it helps with the hydration.**
- **Limit your alcohol intake 24 hours before your screening**
- **Take all of your prescribed medication as directed by your physician**
- **Refrain from smoking 1 hour before your screening** (as it may affect your blood pressure)

Please return the completed Consent form to Baptist Health Employer Solutions using one of the following methods:

MAIL: Baptist Health Employer Solutions
RE: Healthier You
2501 Nelson Miller Parkway, Suite 102
Louisville, KY 40223
ATTN: Mina Schelling

FAX: (502) 254-6090 (Re: Healthier You/ ATTN: Mina Schelling)

SECURE E-MAIL: wellnesscoordinator@BHSI.com (Subject: Healthier You)

If you have any questions, please do not hesitate to contact Mina Schelling via email at Mina.Schelling@bhsi.com or by phone at (502)899-2899.

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☐ **Initial** ☐ **End of Phase 1** ☐ **End of Phase 2**

Consent for Release for Wellness Assessment/Screening

This Personal Health Screening/Assessment is intended to help you understand health risks you may face and offer suggestions on how best to minimize or eliminate these risks. The information you provide WILL BE KEPT STRICTLY CONFIDENTIAL and generally individual information WILL NOT BE SHARED WITH YOUR INSURANCE CARRIER OR HEALTH PLAN. Any information shared with your employer WILL NOT INDENTIFY ANY SINGLE INDIVIDUAL and will only be presented to represent the workforce as a whole. If your employer's health plan offers an incentive program which includes participation (not outcomes/results) in biometric screenings, your participation will be shared as applicable. We may share your information with vendors that perform certain health or wellness services for your employer or health plan or who assist us in performing our services.

This assessment is not intended to establish a patient-health professional relationship nor replace any advice provided by your physician. Information you provide may be made available to health resource experts whose product or services may be appropriate to help you reduce health risks you may face. Your participation in these initiatives is strictly voluntary.

You hereby consent to the performance of your health screening, which may include the drawing of blood samples. You agree to release all organizations associated with this screening, their affiliates, directors, officers, employees, successors, and assigns, from any and all liabilities arising from or in any way connected with this health survey or blood drawing. You understand that the data derived from these tests is considered preliminary and does not constitute a diagnosis. The responsibility for initiating a follow-up examination to confirm the results of these screenings and obtain professional, medical assistance is yours alone and not that of any organization associated with this screening.

Please provide all information requested below:

Full Legal Name (print): (last)_____(first)_____(MI)_____

Age: _____ Date of Birth: _____ Gender: M / F Employee ID # _____ Las 4 of SSN: ___/___/___/___

Email: _____ Preferred Phone: _____

Address: _____ City: _____ ST: _____ Zip: _____

Please answer the following questions:

1. Are you a diabetic? Y / N
2. Do you have a primary care doctor Y / N

   Doctor Name: _____
3. Do you use tobacco? Y / N
   (Tobacco use means any tobacco product in the previous 6 months)
4. Please circle any that you are currently being treated for:

   High Blood Pressure Diabetes High Cholesterol Asthma

Complete this section if you are <u>NOT</u> employed by the company above: *(Dependents under age 18 require signature of Parent or Guardian)

Employee Name (PRINT <u>Full Legal Name</u>): _____

Relationship to Employee: ☐ **Spouse** ☐ **Dependent*** ☐ **Other**_____

Signature:_____**Date:**_____

Clinic Staff Use Only – RESULTS: ☐ Fasting ☐ Non-Fasting

Height_____(total inches) Weight _____(lbs) BMI_____

Abdominal Circumference_____(at navel, round down to nearest quarter inch) Blood Pressure _____

Total Cholesterol_____ TRIG _____ HDL_____ LDL_____A1C OR Glucose_____
(Circle One)

Rev 12-28-15 (LS)

Staff Initials _____