Health Coaching Program Medical Clearance Form

Dear Health Coaching Participant,

Please have your healthcare provider, such as your physician, nurse practitioner or physician's assistant complete the following. The provider can be a CareATC provider or your personal physician, such as your primary care physician or specialist.

There is no charge for a CareATC provider to complete this form. However, if your personal physician requests that you be seen, the visit is subject to a copay or if your personal physician charges to complete release forms, the completion of this form could be subject to their charges to complete forms.

Health Coaching Participant Name _____

Phone _____ Email_____

Dear Healthcare Provider,

☐ Based on out of range biometric markers, your patient is accessing health coaching as a reasonable accommodation to qualify for a premium incentive tier through the Tulsa FOP 93 Health & Welfare Trust.
☐ Based on your patient's interest and not out of range biometric markers, he/she is participating in health coaching.

The activities involved in the program could include: motivational interviewing, goal setting, shared decision making, stress management, tobacco cessation, nutritional counseling, exercise programming, etc. Health coaching is not a diet or exercise program. However, if your patient decides that their goal is related to diet and/or exercise, these topics might be discussed.

Your patient's health coach will have a bachelor's degree in health and wellness or a related field and will have a certification in evidenced-based health coaching or related certification.

By completing the form below, you are not assuming any responsibility for the administration of this health coaching program. If you know any medical or other reason why your patient's participation in this program would be unwise or unnecessary, please indicate so below.

☐ I know of no reason why my patient may not participate.
☐ I recommend that my patient NOT participate in this health coaching program at this time for medical or other reasons.
☐ I believe my patient can participate, but I urge caution. Please identify any recommendations or restrictions that are appropriate for your patient, particularly as it applies to nutrition and/or exercise:

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_____

Healthcare Provider (Print) Healthcare Provider (Signature) Date

_____

Address City State Zip Phone

Please email this form to healthcoaching@wellbeingsolutionsok.com.
For questions, please email healthcoaching@wellbeingsolutionsok.com or call 918-344-4859.

Revised: August, 2019