NKU PCP VISIT FORM

Completed by Participant:
Consent to use information: I, participant, hereby authorize my provider to release information within this form to Northern Kentucky University. I understand that University Wellness will solely use this information for the purposes of administration of the NKU Cares Primary Provider program. This from must be signed directly by the primary care provider and not by a medical office staff member or the patient himself/herself.

Last Name: _____

First Name: _____

Faculty or staff: _____

Department: _____

Completed by Primary Care Provider:
*This portion must be directly signed by the primary care provider and not by a medical staff member or the patient.

As the primary care provider for this patient, I have taken the time during this office visit to discuss my patient's personal well-being goals, biometrics, and lifestyle behaviors with them and have provided feedback and counseling as appropriate.

Primary Care Provider Name:

_____

Date: _____

Primary Care Provider Signature:

_____

NKU University Wellness