

# *Sign up for your diabetes management program*



*FREE diabetes  
meds & supplies*



*FREE Wellness  
Center  
membership*



*Online and  
one-on-one  
education*



*FREE quarterly  
labwork*

Health Matters is a **FREE** disease management program for employees that have been diagnosed with type 1 or type 2 diabetes or pre-diabetes and are insured by Huntsville Hospital.

**OPEN ENROLLMENT**  
**JULY 20 - AUGUST 28**

Registration forms are available on the Pulse page and at the HealthWorks 2.0 office.



*Your employee disease management program*

# Huntsville Hospital HealthMatters Diabetes Management Application

Name \_\_\_\_\_ Employee ID# \_\_\_\_\_  
 Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Physician \_\_\_\_\_ Phys phone \_\_\_\_\_  
 Cigna Group No. \_\_\_\_\_ Member ID \_\_\_\_\_

**Health History:** \_\_\_ Type 1 Diabetes \_\_\_ Type 2 Diabetes \_\_\_ Pre-Diabetes  
 \_\_\_ Insulin Resistance \_\_\_ High Blood Pressure \_\_\_ High Cholesterol  
 \_\_\_ Polycystic Ovarian Syndrome  
 Other \_\_\_\_\_

### Program Benefits:

- ✓ **Free** diabetes medications, lancets, and test strips through **Employee Pharmacy**
  - ✓ **Free** 12-month **Wellness Center** membership
- ✓ **Free** diabetes education and support through Huntsville Hospital's **HealthWorks, Diabetes Control Center, and Wellness Centers**

### Mandatory Requirements:

\*Please initial if you agree:

- ✓ **Attend kick-off meeting** \* \_\_\_\_\_
- ✓ **Huntsville Hospital employee on hospital insurance** \* \_\_\_\_\_
- ✓ **Complete Diabetes Education courses** \* \_\_\_\_\_
- ✓ **Complete initial labs, health/fitness assessments** \* \_\_\_\_\_
- ✓ **Commit to exercising at least 8 x per month** \* \_\_\_\_\_
- ✓ **Follow your Physician's orders regarding your diabetes** \* \_\_\_\_\_
- ✓ **Have labs drawn (no cost) at a HH lab every 3 months** \* \_\_\_\_\_
- ✓ **Attend quarterly care manager and group meetings** \* \_\_\_\_\_

**Please complete the following chart (may attach additional sheet if needed):**

Drug	Dose	How taken (orally etc.)	How Often

**IMPORTANT:** Return this completed application *in person* to **HealthWorks**, Blackwell Medical Towers Suite 10. The **Physician Approval Form**, downloadable from Pulse, must be completed by your primary care physician. (*BOTH forms must be completed and the information returned to HealthWorks to be eligible for benefits.*) **Questions? Call 256-265-6288.**



**HealthMatters Physician Approval and Medical Clearance**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**Medical Clearance for Exercise**

For the HealthMatters program, your patient will be required to participate in an exercise program at Huntsville Hospital's Wellness Center. Your patient has completed a readiness questionnaire which has highlighted the need for a medical clearance. By completing this form, you are not assuming responsibility for our program. If however, you know of any reason why your patient should not undertake a basic assessment of fitness, please indicate the reasons below.

No medical restrictions to exercise     Refer patient to physician before engaging in exercise program

Restrictions of the following: \_\_\_\_\_

**Diagnosis**

250.00 Type 2     250.01 Type 1     250.02 Type 2, uncontrolled     250.03 Type 1, uncontrolled

Other \_\_\_\_\_

Is the patient treated with insulin?    Yes     No                      Using an insulin pump?    Yes     No

Is the patient treated with oral agents?    Yes     No

Comments \_\_\_\_\_

Diet order \_\_\_\_\_

**Dispense as Written**

**Test Strips:**    50 strips     100 strips     Other amount \_\_\_\_\_

**Glucose Meter:**    Meter as specified by HealthMatters

**Frequency of Monitoring Ordered**

Daily     2 times a day     3 times a day     4 times a day     Other \_\_\_\_\_

**Documentation**

Co morbidities:    Hypertension     Peripheral vascular disease     Neuropathy     Visual impairment

Dyslipidemia     ESRD     Other \_\_\_\_\_

Complicating/aggravating circumstances:    Hospitalization: Last date admitted: \_\_\_\_\_

Other \_\_\_\_\_

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Physician's name (printed): \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\*\*The HH Healthy System Lab will fax your patient's **HealthMatters** free lab results to your office every 3 months. \*\*

**\*\*Please return this form to your patient or fax to HealthWorks at (256) 265-6278\*\***