

## Preventive Screening Form

**Provider Information** (please print clearly)

Please complete this section of the form indicating that your patient is up to date on preventive screenings based on the U.S. Preventive Services Task Force (USPSTF) recommendations.

Date of Last Physical:	Date of Last Mammogram:	Date of Last Cervical Cancer Screening:
Date of Last Colon Cancer Screening: _____		
Screening Test: <input type="checkbox"/> Fecal Occult Test <input type="checkbox"/> FIT Test <input type="checkbox"/> Cologuard <input type="checkbox"/> Colonoscopy or Flex Sig		
Physician Name (Print):		
Physician Signature:		Date:
Specialty Type: <input type="checkbox"/> Family Practice <input type="checkbox"/> Internal Medicine <input type="checkbox"/> OB/GYN		

**Member Information** (please print clearly)

Member Name:	Date of Birth:
Email:	Member ID:
Member Signature:	Date:

**Please submit this form by October 31, 2023**

All completed forms can be emailed to [formsubmission@group-health.com](mailto:formsubmission@group-health.com) or mailed to Group Health Cooperative of Eau Claire, Attn: Health Promotion 2503 N. Hillcrest Parkway Altoona, WI 54720