group health Cooperative of eau claire

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 Colon Cancer Screening: ______________________

Screening Test: ☐ Fecal Occult Test ☐ FIT Test ☐ Cologuard ☐ Colonoscopy or Flex Sig

Date of Last Cervical Cancer Screening: ______________________

Screening Test: ☐ Pap Test ☐ Pap+HPV Test

Physician Name (Print):

Physician Signature:	Date:

Specialty Type: ☐ Family Practice ☐ Internal Medicine ☐ 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, 2024

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

Please keep a copy for your records.