COMPASS HEALTH
WELLNESS & PREVENTION

ANNUAL/PREVENTATIVE EXAM PROOF OF VISIT

You will receive 20 points for each screen completed.

Patient Information (Please Print):

First Name:____________________________ Facility: ______________________________

Last Name:____________________________ Phone #: ______________________________

Date of Birth:__________________________ Email: ________________________________

Physician Information:

Physician Office/Name: ____

Office Phone/Address: ____

Date of Visit: _______________________

General:
**Required annually for Wellness Program eligibility*

☐ *Annual Preventative Exam (physical performed by Primary Care Physician)

☐ *Blood Screening

☐ Eye Exam

☐ Colorectal Exam

☐ Dental Exam

Women:

☐ Annual OB/GYN Exam (Pap)

☐ Mammogram

Men:

☐ Prostate

Physician Certification

I certify that the patient listed above received the tests indicated on this form on:

Month ___________________ Day________Year ________

Physician Signature: ____________________________________

1.01.2016