COMPASS HEALTH
WELLNESS & PREVENTION

Annual/Preventative Exam Proof Of Visit

You will receive 20 points for each exam completed.

Patient Information (Please Print)

First Name: _____ Facility: _____

Last Name: _____ Phone Number: _____

Date of Birth: _____ Email: _____

Physician Information (Please Print)

Physician Office / Name: _____

Office Phone / Address: _____

Date of Visit: _____

Exam: PLEASE USE ONE FORM PER EXAM

**Required annually for Wellness Program eligibility*

- ❑ ****Annual Preventative Exam*** Date: _____ **20pts**
  (Physical Performed by Primary Care Physician)
- ❑ ****Blood Screening*** Date: _____ **20pts**
- ❑ **Eye Exam** Date: _____ **20pts**
- ❑ **Colorectal Exam** Date: _____ **20pts**
- ❑ **Dental Exam** Date: _____ **20pts**
- ❑ **Annual OB/GYN Exam (Pap)** Date: _____ **20pts**
- ❑ **Mammogram** Date: _____ **20pts**
- ❑ **Prostate** Date: _____ **20pts**
- ❑ **Other: _____** Date: _____ **20pts**

Physician Certification

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

Date: _____

Physician Signature: _____

Points on this sheet: _____