# Preventative Care Form

Please fax completed forms and medical record documentation to **833-667-1532** or send to our secure email **MIHEDIS@mhplan.com** and save a copy in the patient's medical record.

Patient Name: _____ DOB: _____

ID#: _____

| Cervical Cancer Screening | Colorectal Cancer Screening |
|---|---|
| Date of Pap Screening: ___/___/____<br><br>Result: _____<br><br>Date of HPV Screening: ___/___/____<br><br>Result: _____ | Date of Screening: ___/___/____<br><br>Type of Screening:<br>Colonoscopy ☐ FIT-DNA (Cologuard) ☐<br>FOBT ☐ Flexible Sigmoidoscopy ☐<br><br>Result:_____ |
| **Chlamydia Screening** | **Breast Cancer Screening** |
| Date of Screening: ___/___/____<br>Result (choose one):<br>○ Positive ○ Negative | Date of Screening: ___/___/____<br><br>Result: _____ |

Provider Signature: _____ Date: ___ /___ /_____

Provider Name and Credentials (Print): _____

If an office or clinical support staff member fills out the form, it must be routed back to the provider for follow-up and signoff.

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