2017 Women's Physician Preventive Service Form

Name_________________________________ Date of Birth____________________

Please complete the following form, indicating the last date of service for each group of preventive services marked below. Physicians should indicate "**EXEMPT**" in place of the date for those services that are inappropriate or unnecessary for a participant to receive due to a medical condition or circumstance. **Please return this form by September 30, 2017.**

Preventive Services for Women*:

18-39	Frequency	Completed After	Date & Initials
Hypertension screening (Office blood pressure measurement)	Every 2 years	Jan. 1, 2015	
Cervical Cancer screening (Pap Smear) **21 and older OR**	Every 3 years	Jan. 1, 2014	
Cervical Cancer screening (Pap Smear) **AND** HPV testing **30 and older**	Every 5 years	Jan. 1, 2012	
40-44			
Hypertension screening (Office blood pressure measurement)	Every 2 years	Jan. 1, 2015	
Cervical Cancer screening (Pap Smear) **OR**	Every 3 years	Jan. 1, 2014	
Cervical Cancer screening (Pap Smear) **AND** HPV testing	Every 5 years	Jan. 1, 2012	
45-49			
Hypertension screening (Office blood pressure measurement)	Every 2 years	Jan. 1, 2015	
Cervical Cancer screening (Pap Smear) **OR**	Every 3 years	Jan. 1, 2014	
Cervical Cancer screening (Pap Smear) **AND** HPV testing	Every 5 years	Jan. 1, 2012	
50-64			
Hypertension screening (Office blood pressure measurement)	Every 2 years	Jan. 1, 2015	
Cervical Cancer screening (Pap Smear) **OR**	Every 3 years	Jan. 1, 2014	
Cervical Cancer screening (Pap Smear) **AND** HPV testing	Every 5 years	Jan. 1, 2012	
Breast Cancer screening (Mammogram)	Every 2 years	Jan. 1, 2015	
Colonoscopy **OR**	Every 10 years	Jan. 1, 2007	
Sigmoidoscopy **OR**	Every 5 years	Jan. 1, 2012	
Fecal Occult Blood Test	Every year	Jan. 1, 2016	
65+			
Hypertension screening (Office blood pressure measurement)	Every 2 years	Jan. 1, 2015	
Breast Cancer screening (Mammogram)	Every 2 years	Jan. 1, 2015	
Colonoscopy **OR**	Every 10 years	Jan. 1, 2007	
Sigmoidoscopy **OR**	Every 5 years	Jan. 1, 2012	
Fecal Occult Blood Test	Every year	Jan. 1, 2016	
Osteoporosis screening	Once	Ever	
Pneumonia Vaccine	Once	Ever	

Physician Name________________________ Physician Signature_________________________

**IYL requirements represent minimum standards for screening of the general population based on age, gender and diabetes status. Talk to your doctor about your values and personal and family health history to decide which additional or more frequent tests may be right for you.*

If it is unreasonably difficult due to a medical condition or medically inadvisable for you to meet the requirements of the It's Your Life program as described, call us at (517) 205-7495 and we will work with you and your physician to develop another way to meet the requirements.

Completed forms may be returned by fax or mail to:
Prevention and Community Health
One Jackson Square, 9th floor
Jackson, MI 49201
Phone: (517) 205-7495 Fax: (517) 205-5941