



**Bill Whitters Construction Inc**  
**2020 Preventive Care & Screening Form**



**TO BE COMPLETED BY THE MEDICAL PROVIDER:**

Today's Date: \_\_\_\_\_ Name of Medical Provider: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Medical Provider Mailing Address: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Date of Exam: \_\_\_\_\_ Medical Provider Telephone Number: \_\_\_\_\_

Please check all that are applicable for this patient		
Screening	Applicable Employees	Completed (check box)
Routine physical in the last 12 months	All Employees	
Visual skin cancer exam in past 12 months	All Employees	
CBC in past 12 months	All Employees	
Metabolic screening in past 12 months	All Employees	
Cholesterol screening in past 12 months	All Employees	
Glucose screening in past 12 months	All Employees	
Colonoscopy in last 10 years	Employees 50+ years old	
Pelvic exam and pap in last 12 months	Female Employees 21-29 years old	
Pelvic exam and pap in last 3 years	Female Employees 30+ years old	
Osteoporosis screening in past 5 years	Female Employees 60+	
Discussed prostate exam and PSA test	Male Employees 50+	

**Attention: Medical Providers**

Please submit forms to:

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