Dear Physician,

In an effort to improve awareness of the importance of preventive health practices, Marquette University is asking their employees to verify their annual exam and preventive screening status. Your patient is an employee or spouse/same-sex domestic partner of a Marquette University employee and is requiring your assistance to verify that they have had an annual physical exam and that they are up-to-date on the listed cancer screening tests, or that these tests are not warranted at this time. Please verify the status of these tests by completing the attached form and returning it via mail or fax to the phone/address listed on the bottom.

Thank you in advance for your cooperation with this health promotion effort of Marquette University. If you have any questions please feel free to contact the Aurora Total Health Department at 877-765-3213, Option #1.
2014/15 Marquette University Preventive Care Verification Form

SECTION I: TO BE COMPLETED BY MARQUETTE UNIVERSITY EMPLOYEE/SPOUSE/SAME SEX DOMESTIC PARTNER (Please Print)

Date: ___________  Company Name: Marquette University

First Name: ___________________  Last Name: ___________________  Date of Birth: ___________

Address: _____________________________________  City: _______________  State: _____  Zip: _______

Home Phone: (   )____________________  Work Phone: (   )___________________________

Email Address: _____________________________________________________________________________

Sex:   Male   Female  Employee (ID# _____________________________)

Patient Signature to release information to Aurora: ________________________________________________

SECTION II: TO BE COMPLETED BY PHYSICIAN (Please check one box for the physical exam and one box for each test.)

Annual Physical Exam (Men and Women)
My patient is (check one):  □ Up-to-date. Date of last physical exam: _ _/ _ _/ _ _ _
□ Not Applicable. Note reason: ______________________________________________________________
□ Not up-to-date

Cervical Cancer Screening - Pap Test (Women)
My patient is (check one):  □ Up-to-date. Date of last pap test: _ _/ _ _/ _ _ _
□ Not Applicable. Note reason: ______________________________________________________________
□ Not up-to-date

Breast Cancer Screening – Mammogram (Women)
My patient is (check one):  □ Up-to-date. Date of last mammogram: _ _/ _ _/ _ _ _
□ Not Applicable. Note reason: ______________________________________________________________
□ Not up-to-date

Colorectal Cancer Screening – Colonoscopy or Screening Test (Men and Women)
My patient is (check one):  □ Up-to-date. Date of last colorectal screening: _ _/ _ _/ _ _ _
Type of Colorectal Cancer screening test: ______________________________________________________
□ Not Applicable. Note reason: ______________________________________________________________
□ Not up-to-date

Physician’s Signature: _______________________________________________________________________

Physician’s Name (Please Print): _____________________________________________________________________

Physician’s Address: ____________________________________________________________________________

Physician’s Phone Number: ________________________________________________________________________

Please email/fax/mail this form no later than October 31, 2015 to:

Email: joan.stigler@aurora.org  Fax: (414) 525-2570
Mail: Aurora Health Care Total Health Department / 11217 W. Forest Home Avenue, 1E, Franklin, WI 53132