SCREENING TESTS

July 01 through June 30

(Name of Medical Facility:) ______________________

(Address of Medical Facility) ______________________

____

____

Patient's Name: ______________________

Blood Pressure Checked: ☐ **Date of Service:** ____________

Cholesterol Checked: ☐ **Date of Service:** ____________

Blood Suger Checked: ☐ **Date of Service:** ____________

Cancer Screening: ☐ **Date of Service:** ____________

Signed by Medical Personnel: ______________________

______________________ (TITLE)

Please do not send medical results.

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