Medicare Wellness Visit

Name:________________________ D.O.B.____/______/_____Exam Date:_______________________

Primary Care Provider: ____

Allergies to Medications: ____

Past personal illnesses, injuries, operations or diagnoses	Date	Hospitalized?

Tobacco use: Yes___No___ If yes, (smoke or chew) how many pack per day?

Alcohol use: Yes___No___ If yes, how many drinks per day?

Drug Use: Yes___No___ If yes, Describe.

____

____

Please List: Medications, Supplements, Vitamins	Route (i.e. oral, topical, etc.)	Date	Frequency (ex. 1-2 times/day)

Add Additional page if further space for medications is needed

Current list of patient's providers and suppliers

Name	Specialty	Reason

Medicare Wellness Visit

Family History: Particularly Parents, Grandparents, Siblings (check those that apply)

__Alcoholism	__Cancer	__High Cholesterol	__Obesity
__Diabetes	__Hypertension	__Stroke	__Thyroid Disease
__Heart Disease	__Liver Disease	__Kidney Disease	__Arthritis
Additional History/Notes:			

Number of servings of fruits and vegetables do you have per day?_______________

How many times per week do you exercise? ______Duration?______Type?________

Hearing loss screen

1 .Do you have trouble hearing the TV or radio when others don't? YES NO

2. Do you have to strain or struggle to hear/understand conversations? YES NO

Function Screen

1. Do you need with preparing meals, transportation, shopping, taking your meds, managing finances or other activities of daily living? YES NO

2. Do you live alone? YES NO

Fall Screen

1. Have you had and injury from a fall in the last year? YES NO

2. Have you had more than one fall in the last year? YES NO

3. If you answered yes to question 1 or 2 please mark the circumstance surrounding the fall(s)

__Tripping over something	__Lightheadedness or palpitation prior to fall	__Loss of consciousness
__Injured	__Needed to see a doctor	__Unable to get up on your own

Home Safety Screen

1. Does your home have rugs, poor lighting, or slippery bathtub or shower? YES NO

2. Does your home LACK grab bars in bathroom, handrails on steps or stairs? YES NO

3. Does your home LACK functioning smoke alarms? YES NO

Advanced Care Planning

Patient Consent: "I consent to discuss end-of-life issues with my healthcare provider."

Patient/Guardian Signature_______________________________________ Date_________________

Patient Health Questionnaire (PQH-9}

Name:___________________________________Date:_________________________

Over the last two weeks, how often have you been bothered by any of the following problems? (Please mark each box with a check to indicate your answer)

	Not at all	Several Days	More than half the days	Nearly Everyday
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling asleep or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself-or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

(Healthcare professional: For interpreting of TOTAL, please refer to accompanying score card).

TOTAL:_________

If checked off any problems, how difficult have these problem made it for you to do your work, take care of things at home, or get along with other people?

___ Not Difficult

___Somewhat Difficult

___Very Difficult

___Extremely Difficult

Medicare Wellness Visit

Name:____

HT:______________ WT:____________ BMI:_____________ BP:________________

Depression Screen: PQH-9 Score

(Min 1-4, Mild 5-9, Mod 10-14, Severe 20-27)

If either Fall Screen question was positive then complete the tug test

(Score____Seconds). Was patient unsteady or high risk> or = 12 seconds _Yes _N

Mini Cognitive Results	Circle One
Patient recalled 3 words	Negative for cognitive impairment
Patient recalled 1-2 words+ normal CDT	Negative for cognitive impairment
Patient recalled 1-2 words+ abnormal CDT	Positive for cognitive impairment
Patient recalled zero words	Positive for cognitive impairment

Patient already has executed an advanced directive? ___Yes __No

If no, patient was given an opportunity to execute an Advanced Directive today? ___Yes __No

Physician Statement: "This individual has the ability to prepare an advanced Directive." ___Yes __No

Physician has completed a physician order for life-sustaining treatment or similar document, reflecting the patient's wishes for an advanced care plan. ___Yes __No

Physician is willing to follow patient's wishes. ___Yes __No

Provider Action Items: Pertinent findings or Yes answers should trigger action items.

Evaluation/referral based on screening	Scheduled Appointment	Notes
		PCP sent copy of plan via HER/Paper

MUST NOTE ACTION PLAN FOR 1. ABNORMAL BMI 2. BLOOD PRESSURE > 139/89 3. POSITIVE DEPRESSION SCREEN.
Any BMI <18.5 or >24.9 is considered "Abnormal" and should be commented upon. BP> 149/89 consider meds.

______________________________MD/DO/NP/PA ______________________________
Provider Signature Clinical Staff Signature

______________________________ ______________________________
Print Name Print Name/Title

Medical Record Number/ Patient Name ____________________

Preventive Screen (Frequency)	Medicare Coverage	Previously Tested (If yes, When?)	Scheduled for Screening
Bone Mass Measurements (every 24 months)	Medicare patients at risk for developing Osteoporosis		
Cardiovascular Screening Blood Tests Lipid panel: Cholesterol, Lipoproteins, Triglycerides (every 5 years)	All Medicare patients (12-hour fast required)		
Colorectal Cancer Screening: Colonoscopy (every 24 months at high risk; every 10 years if not high risk) **Flexible sigmoidoscopy** (every 4 years, or 10 years after a negative screening colonoscopy) **Stool DNA** test (every 3 yrs. if no Sx & negative) **Fecal occult blood test** (annually if negative) **Barium enema** (every 24 months at high risk; every 4 years if not high risk)	Medicare patients age 50 and up (Usually done until age 75)		
Diabetes Screening- Tests (2 screening tests per year for patients with pre-diabetes: 1 screening/ year if not diagnosed with pre-diabetes	Medicare pts with risk factors for diabetes (pts previously diagnosed with diabetes aren't eligible)		
Diabetes Self-Management Training (DSMT) (Up to 10 hrs. training within a continuous 12- month period; subsequent years: up to 2 hrs. of follow-up training each year)	Medicare pts at risk for DM comply. Provider must Rx service. Pay 20% of Medicare-approved charge Part B. Deductible applies		
Glaucoma Screening (annually for pts in one of the high risk groups)	Pts with DM, Fam Hx of glaucoma, African-Americans age 50 and up, or Hispanic-Americans age 65 and up		
Prostate cancer Screening (annually) -Digital rectal exam (optional) -PSA test (optional)	All male patients 50 or older (Provider discretion whether warranted)		
Screening Pap tests and Pelvic Exam (annually if high risk) every 5 years with a HPV negative testing	All female Medicare patients (Usually until age 65)		
Screening Mammography (annually if high risk) (Start age 50 & every 2 yrs. = USPSTF Rec)	All female patients 40 years & older (Provider discretion outside age 50-74)		
Vaccines -Pneumococcal (after age 65) -Seasonal Influenza (annually: fall/winter) -Hepatitis B (scheduled dosages required)	All Medicare patients: -May give both Prevnar13 & Pneumovax-23 if 1 year apart. -Refer to CDC for full recommendations -Hepatitis B, if medium/high risk		
Hep C Antibody testing Once if born 1945-1965 or High Risk	h/o IVDA or bid transfused before '92		
HIV Antibody testing (optional annually)	High risk or pt request		
Chlam, GC, Syphilis & Hep B test (optional/annual)	High risk pts		
Abdominal U/S Screen for AAA (once)	FHx of AAA or Male 65-75 h/o 100 cigs		
Medical Nutrition Therapy (C/S)	DM, Renal Ds or Pts with Provider Rx		

Please follow these instructions:

1. Use the box to draw a clock and put numbers on it.
2. Put the hands on the clock so that the time reads "ten past eleven."