PRE-SCREENING

Exam Information Notes :

PRE-SCREENING		
Have you finished an entire SARS-CoV-2 vaccination regimen as prescribed by the manufacturer and has it been at least 14 days since the vaccine regimen was fully completed? (provider)	[X] Yes	
	[ ] No	
Have you received the full COVID-19 vaccination regimen as prescribed by the manufacturer and has it been at least 14 days since the vaccine regimen was fully completed? (member)	[X] Yes	
	[ ] No	
Do any of the following apply to you or any members of your household?	[ ] Have you had a positive COVID-19 test within the past 14 days or are you currently awaiting the results of a COVID-19 test?	[X] None of the above
	[ ] Have you been instructed to quarantine or isolate by any public health authority or healthcare provider within the past 10 days or is it otherwise recommended that you quarantine based on CDC guidance?	
	[ ] Have you experienced any symptoms of COVID 19 within the last 14 days? (including fever, chills, new cough, shortness of breath or breathing difficulty, fatigue, headache, muscle or body aches, loss of taste or smell, sore throat, congestion, runny nose, nausea/vomiting, diarrhea, skin changes, change in mental status/confusion?)	
If member has NOT been fully vaccinated, have they had known exposure in the last 10 days; close contact of less than 6 feet for a cumulative time of 15 minutes within a 24 hour time period with a person under investigation for or sick with a confirmed or presumptive case of COVID-19 (novel coronavirus)?	[ ] Yes	
	[X] No	
	[ ] N/A	
If yes, provider please choose one of the following:	[ ] I am a fully vaccinated provider and okay to proceed with the visit	
	[ ] I am not vaccinated and must cancel the visit due to positive screening	
What is the temperature of the member?	98.0	

EXAM INFORMATION

Exam Information Notes :

EXAM INFORMATION				EXAMINER		
				Examiner name	Sindhu Silveru	
Date of exam	2022-08-30			**Examiner degree**	[X] MD	[ ] NP
					[ ] DO	[ ] PA
						[ ] MA
Place of exam	[ ] Home	[ ] Long term care setting (nursing home)	[ ] Other	**Examiner NPI**	6604412989	
	[X] Physician Office	[ ] Assisted living facility				
		[ ] Retail health clinic				

MEMBER INFORMATION

Member Information Notes :

PERSONAL DETAILS						
Member first name	Titus		**Member last name**	Carroll		
Date of birth	1973-08-03		**Age**	49		
Gender	M		**City**	Grand Prairie, TX, 4420 Harpers Ferry Dr, 75052		
Race	[ ] American Indian / Alaska Native	[ ] Native Hawaiian or other Pacific Islander	[ ] Asian	**Ethnicity**	[ ] American	[ ] Arab	[ ] African
	[ ] Black / African American	[ ] Other / Multiracial	[ ] White		[ ] Asian	[ ] Hispanic / Latino	[ ] Chinese
					[ ] European	[ ] Japanese	[ ] Other

PERSONAL DETAILS

Preferred language	☐ English	☐ Spanish	☐ Cantonese	**Marital status**	☐ Married	☐ Long-term partner	☐ Widowed
	☐ Mandarin	☐ Russian	☐ Other		☐ Divorced	☐ Single	
Current work status	☐ Employed	☐ Unemployed and seeking work	☐ Unemployed and not seeking work (e.g., retired, disabled, unpaid primary care giver)	**Primary email address**	Lucinda_Jaskolski @example.com		
	☐ N/A						
Member's Plan	CHDemo-TX						

PCP INFORMATION

PCP Information Notes :

PHYSICIAN OF RECORD (PCP)

Do you receive care from the VA (Veterans Administration)?	☐ Yes ☐ No	**In what city do you receive VA care?**	
PCP name	Sindhu Silveru	**PCP Address**	4055 Valley View Ln, 300, Dallas, TX, 75244
PCP phone number	9723334444	**PCP fax number**	2145556666

Is the primary physician (PCP) information listed correct?	☒ Yes	☐ No
Do you have a primary physician?	☐ Yes	☐ No
Have you visited your primary physician within the last 12 months?	☒ Yes	☐ No
Date of next PCP appointment		☒ Unknown / Uncertain

Are any of the listed Clinicians the member's PCP?	**PCP First Name**	**PCP Last Name**	**PCP Street Address 1**	
	PCP Street Address 2	**PCP City**	**PCP State**	**PCP Zip**

CLINICIANS

Clinicians & DME Suppliers Notes :

*****No Clinicians or DME's found*****

MEDICATION REVIEW

Medication Review Notes :

MEDICATION REVIEW

Do you take any prescription medications?	☐ Yes	☒ No		
Do you know why you take the medication(s)?	☐ Yes	☐ No		
Do you have a prescription for oxygen?	☐ Yes	☒ No	☐ Unknown	
Is the oxygen prescribed:	☐ Continuous	☐ Intermittent	☐ At night	☐ As needed
Have you not taken your medications as prescribed because of the cost of the medications (e.g., splitting pills, delaying a prescription, or not filling a prescription)?	☐ Yes	☐ No		
Have you not taken your medications as prescribed because you were unable to access a pharmacy?	☐ Yes	☐ No		

*****No Prescription Medications Found*****

MEDICATION REVIEW RECOMMENDATIONS

☐ H14: Encourage patient education regarding chronic disease and treatment, including side effects	☐ H15: Encourage adherence to treatment regimen, especially for chronic diseases like DM and HTN
☐ H4: Consider evaluation of high risk medications, including anti-psychotics	☐ Consider education/assistance with RA management
☐ R2: Consider DMARD for rheumatoid arthritis management	☐ H54: Consider options (e.g., mail delivery, lower cost drugs) to improve medication adherence (90 day supply)
☐ H23: Consider discussion of medication safety issues	☐ H29: Consider medication list review (e.g. Beers list/high risk medications)
☐ Consider education for maintenance inhaler use	

OTC & SUPPLEMENTS

OTC & Supplements Notes :

No OTC Medications or Supplements Found

ARE ANY OF THE FOLLOWING USED REGULARLY?					
☐ Multivitamin	☐ Calcium supplements	☐ Antacid/PPI	☐ Naproxen (Aleve)	☐ Aspirin, intermittent use	☐ Antihistamine
☐ Vitamin D	☐ Fish oil	☐ Ibuprofen (Advil)	☐ Aspirin, chronic use	☐ Acetaminophen (Tylenol)	

Reason(s) for OTC or Supplement use?					
	☐ Pain	☐ Preventive	☐ Osteoarthritis	☐ GERD	☐ Other

ALLERGY REVIEW

Allergy Review Notes :

ALLERGY HISTORY			
Allergy Review	☐ Not obtainable	☐ NKA	☐ Positive history
Reason allergy history not obtainable			

ALLERGIC REACTION (MARK ONLY MOST SERIOUS)					
DRUG	Penicillin	☐ Rash/urticaria	☐ Angioedema	☐ Wheezing	☐ Anaphylaxis
	Tetracycline	☐ Rash/urticaria	☐ Angioedema	☐ Wheezing	☐ Anaphylaxis
	Sulfonamide	☐ Rash/urticaria	☐ Angioedema	☐ Wheezing	☐ Anaphylaxis
	Cephalosporin	☐ Rash/urticaria	☐ Angioedema	☐ Wheezing	☐ Anaphylaxis
	NSAID/aspirin	☐ Rash/urticaria	☐ Angioedema	☐ Wheezing	☐ Anaphylaxis
	ACEi/ARB	☐ Rash/urticaria	☐ Angioedema	☐ Wheezing	☐ Anaphylaxis
	Radiographic dye	☐ Rash/urticaria	☐ Angioedema	☐ Wheezing	☐ Anaphylaxis
	Vaccine	☐ Rash/urticaria	☐ Angioedema	☐ Wheezing	☐ Anaphylaxis
FOOD	Peanuts	☐ Rash/urticaria	☐ Angioedema	☐ Wheezing	☐ Anaphylaxis
	Milk	☐ Rash/urticaria	☐ Angioedema	☐ Wheezing	☐ Anaphylaxis
	Eggs	☐ Rash/urticaria	☐ Angioedema	☐ Wheezing	☐ Anaphylaxis
	Seafood	☐ Rash/urticaria	☐ Angioedema	☐ Wheezing	☐ Anaphylaxis
OTHER	Insects/spiders	☐ Rash/urticaria	☐ Angioedema	☐ Wheezing	☐ Anaphylaxis
	Latex	☐ Rash/urticaria	☐ Angioedema	☐ Wheezing	☐ Anaphylaxis
	Other	☐ Rash/urticaria	☐ Angioedema	☐ Wheezing	☐ Anaphylaxis
	Specify other (significant) allergen				

CHART REVIEW

Chart Review Notes :

No Past Diagnoses Documented

DOCUMENTED & ADDITIONAL DIAGNOSES

Documented & Additional Diagnoses Notes :

No Additional Diagnoses Documented

RECOMMENDATIONS	
☐ H25: Consider visiting with your physician regularly	☐ H14: Encourage patient education regarding chronic disease and treatment, including side effects

LABS & PROCEDURES

Labs & Procedures Notes :

LABS & PROCEDURES			
Labs and Procedures	Exam Date:	Procedure:	Results:

I have reviewed all labs and procedures reported in this section	☒ Yes

RECOMMENDATIONS
☐ D1: Consider A1c testing

FAMILY HISTORY & HEALTH ASSESSMENT

Family History & Health Assessment Notes :

FAMILY HISTORY					
Relevant positive family history (in parents, siblings, or children)	☐ Yes	☒ No	☐ N/A		
Positive Family History	☐ Breast cancer	☐ COPD	☐ Hypertension	☐ Psychiatric disorder	☐ Other family history
	☐ Alcoholism	☐ Other cancer	☐ Diabetes	☐ Ischemic heart disease	☐ Stroke
If Other, please specify					

HOSPITALIZATIONS AND URGENT CARE REVIEW					
In the past 12 months, how many times have you visited an ER or urgent care?	☐ 0	☒ 1	☐ 2	☐ 3 or more	☐ Unknown
In the past 12 months, how many separate times have you stayed overnight in a hospital?	☐ 0	☒ 1	☐ 2	☐ 3 or more	☐ Unknown
What was the discharge date of your last hospitalization?		☐ Unknown/Uncertain			
What was the primary diagnosis from your last hospitalization?					

GENERAL HEALTH			
Compared to other people your age, how would you describe your health?	☐ Excellent	☐ Very good	☐ Good
	☐ Fair	☐ Poor	☐ Refused
	☐ Don't know/not sure		
PHYSICAL HEALTH: Compared to 1 year ago, how would you rate your physical health in general now?	☐ Much better	☐ Slightly better	☐ About the same
	☐ Slightly worse	☐ Much worse	
EMOTIONAL HEALTH: Compared to 1 year ago, how would you rate your emotional health (such as feeling anxious, depressed, or irritable) in general now?	☐ Much better	☐ Slightly better	☐ About the same
	☐ Slightly worse	☐ Much worse	
In the past 4 weeks, have you had too little energy to do the things you want to do?	☐ Yes	☐ No	
During the past 30 days, how many days did poor physical or mental health keep you from your usual activities, self-care, or recreation?	☐ 0-5	☐ 6-10	☐ 11-15
	☐ 16-20	☐ 21-25	☐ 26-30

SAFETY & FUNCTIONAL REVIEW (COA)

Safety & Functional Review (COA) Notes :

SAFETY & FUNCTIONAL REVIEW (COA)			
What is your current living situation?	☒ I have a steady place to live	☐ I do not have a steady place to live	☐ I have a place to live today, but I am worried about losing it in the future
	☐ Unknown		
Are you currently living alone?	☐ Yes	☐ No	
How often have you felt lonely or isolated from those around you?	☐ Never	☒ Rarely	☐ Sometimes
	☐ Often	☐ Always	☐ Unknown
Are you a caregiver for someone else?	☐ Yes	☐ No	
Who else lives with you? (Check all that apply)	☐ Spouse / domestic partner	☐ Child / children	☐ Long-term care setting
	☐ Other family / friend	☐ Other	
Do you need help to go out of the house?	☐ Yes	☐ No	
Because of financial concerns, do you have to make choices between food, medication, heat, or other necessities?	☐ Yes	☒ No	☐ Unknown
Specify choice(s) due to financial concerns	☐ Food	☐ Medications	☐ Electric / gas service
	☐ Telephone	☐ Transportation	☐ Other
Do you have any special needs?	☐ Yes	☐ No	
Specify special need(s)	☐ Difficulty seeing	☐ Difficulty reading	☐ Difficulty hearing
	☐ Interpreter needed	☐ Other	

SAFETY & FUNCTIONAL REVIEW (COA)

Do you have home safety issues that need to be addressed?	☐ Yes	☒ No	☐ Unknown
Specify safety issues that need to be addressed	☐ Bathroom modifications	☐ Access ramp / modifications	☐ Loose rug restraint
	☐ Hand rails	☐ Improved lighting	☐ Pest control
	☐ Mold present	☐ Lead paint/pipes	☐ No heat/air conditioning
	☐ Lacking/nonfunctional smoke detectors	☐ Water leaks	☐ Oven/stove not working
	☐ Other		
Do you feel unsafe in your home?	☐ Yes	☐ No	
Specify services and/or support that might help	☐ Counseling services	☐ Help with anger management	☐ Help with financial stressors
	☐ Other		
Do you use durable medical equipment (DME) on a regular basis?	☐ Yes	☐ No	
Specify DME equipment	☐ Cane or quad cane	☐ Wheelchair, manual	☐ Wheelchair, powered
	☐ Walker, standard	☐ Walker, rolling	☐ Raised toilet seat
	☐ Scooter	☐ Hospital bed	☐ Other
Does your caregiver provide adequate support for your needs?	☐ Yes	☐ No	☐ N/A
Do you regularly use a seat belt when in a motor vehicle?	☐ Yes	☐ No	

ACTIVITIES OF DAILY LIVING

Do you have any difficulty doing things like bathing or dressing yourself, or getting around the house?	☐ Yes	☒ No	
Specify ADL difficulty	☐ Bathing	☐ Dressing	☐ Incontinence / toileting
	☐ Getting around the house	☐ Grooming	☐ Feeding yourself
	☐ Getting in or out of bed or a chair	☐ Other	
Do you have difficulty paying bills, buying groceries, etc (instrumental activities of daily living)?	☐ Yes	☐ No	
Specify IADL difficulty	☐ Using the telephone	☐ Managing money	☐ Preparing meals
	☐ Shopping and errands	☐ Managing medications	☐ Laundry or housekeeping
	☐ Driving / arranging transportation		

RECOMMENDATIONS

- ☐ H28: Consider annual functional assessment of at-risk senior
- ☐ Multiple Sclerosis impacting ADLs, consider assistance with resources
- ☐ Parkinson's disease impacting ADLs, consider assistance with resources

PREVENTIVE SERVICES

Preventive Services Notes :

PREVENTIVE SERVICES

What is the date of your last flu vaccine?	Month: Day: Year:	☒ Member has not received flu shot	☐ Member declines to answer
Have you ever had one or more pneumonia shots?	☐ Yes	☐ No	☐ N/A
When did you get it (best estimation)?	☐ Unknown / Uncertain	Month: Day: Year:	
Have you ever received a vaccine for shingles (Herpes Zoster)?	☐ Yes	☐ No	☐ N/A
When did you get it (best estimation)?	☐ Unknown / Uncertain	Month: Day: Year:	
Have you had a tetanus/diphtheria/whooping cough/pertussis (TD/TDap) vaccine within the last 10 years?	☐ Yes	☐ No	☐ N/A
When did you get it (best estimation)?	☐ Unknown / Uncertain	Month: Day: Year:	

RECOMMENDATIONS

- ☒ H7: Consider influenza vaccination annually
- ☐ H8: Consider appropriate pneumococcal immunization
- ☐ H19: Consider colorectal cancer screening
- ☐ H3: Consider baseline or repeat evaluation for osteoporosis or medical therapy
- ☐ H35: Consider Herpes zoster (shingles) vaccine

LABS

Labs Review Notes :

GLUCOMETER			
Do you have an operational glucometer?	☐ Yes	☐ No	☐ Unknown
Blood Sugar 1	Result:		
Blood Sugar 2	Result:		
Blood Sugar 3	Result:		
Do you use your glucometer regularly?	☐ Yes	☐ No	☐ Unknown

FROM VALIDATED REPORT(S)			
Member has had A1c checked in the last 12 months	☐ Yes	☐ No	☐ Unknown
Recent A1c results (%)	Result:		
Member has had eGFR checked in the last 12 months	☐ Yes	☐ No	☐ Unknown
Recent eGFR results (mL/min/1.73m^2)	eGFR value:		
Member has had a test to check for protein in their urine in the last 12 months	☐ Yes	☐ No	☐ Unknown
Urine protein test results	Result:		

ASSESSMENT			
☐ Dx: Hyperglycemia			
☐ Dx: Chronic kidney disease (CKD)			
☐ Dx: CKD Stage	☐ Unspecified CKD	☐ Stage 1 CKD	☐ Stage 2 CKD
	☐ Stage 3A CKD	☐ Stage 3B CKD	☐ Stage 4 CKD
	☐ Stage 5 CKD	☐ ESRD	
☐ Dx: Dialysis, chronic			

RECOMMENDATIONS	
☐ D1: Consider A1c testing	☐ Recommend education regarding Chronic Kidney Disease management

GENERAL & PAIN

General & Pain Notes :

GENERAL			
Member can provide a reliable history	☐ Yes	☐ No	
Alternate historian is available	☐ Yes	☒ No	
Alternate historian name			
Relationship of alternate historian to member	☐ Spouse	☐ Child	☐ Parent
	☐ Other family/friend	☐ Paid caregiver	☐ Other
Do you have an Advance Health Directive (Living Will)?	☐ Yes	☐ No	☐ Unknown
Do you have a Medical Power of Attorney?	☐ Yes	☐ No	☐ Unknown
Have you had an organ or tissue transplant?	☐ Yes	☐ No	
Organ(s) or tissue transplanted?	☐ Bone marrow	☐ Heart	☐ Kidney
	☐ Liver	☐ Lung	☐ Other
Date of most recent transplant	☐ Unknown / Uncertain		
In the past 12 months, have you spoken with your doctor or other health care provider about your level of exercise or physical activity?	☐ Yes	☐ No	
In the past 12 months, did a doctor or other health care provider advise you to start, increase or maintain your level of exercise or physical activity?	☐ Yes	☐ No	

PAIN ASSESSMENT			
Do you have pain or are you being treated for pain?	☐ Yes	☒ No	
Pain being treated regularly?	☐ Yes	☐ No	
During the last 4 weeks, how much did pain interfere with your normal work (including working outside the home and housework)?	☐ Not at all	☐ A little bit	☐ Moderately
	☐ Quite a bit	☐ Extremely	☐ Refused
	☐ Unknown		
Pain level scale	☐ Pain level of 0; No pain	☐ Pain level of 1; Mild pain	☐ Pain level of 2; Mild pain
	☐ Pain level of 3; Mild pain	☐ Pain level of 4; Mild pain	☐ Pain level of 5; Moderate pain
	☐ Pain level of 6; Moderate pain	☐ Pain level of 7; Severe pain	☐ Pain level of 8; Severe pain
	☐ Pain level of 9; Severe pain	☐ Pain level of 10; Worst pain imaginable	☐ Unknown

PAIN ASSESSMENT			
Pain duration	☐ <1 month	☐ 1-6 months	☐ >6 months
	☐ Unknown		
Type of pain	☐ Dull	☐ Sharp	☐ Constant
	☐ Intermittent	☐ Electric/Shooting (neuropathic)	☐ Visceral
	☐ Unknown		

GENERAL & PAIN ASSESSMENT	
☐ Dx: Long term use of opiate	☐ Dx: Chronic pain
☐ Dx: Neuropathic pain	

RECOMMENDATIONS	
☐ H1: Consider Advanced Care planning, including DNR, Advance Directive, Living Will, Medical Power of Attorney	☐ H24: Consider discussing level of physical activity
☐ H12: Encourage exercise at least 30-60 minutes per day	☐ H26: Consider a pain management program

HEENT & PULMONARY

HEENT & Pulmonary - Review Notes :

HEENT			
Have you seen an ophthalmologist or optometrist in the last 12 months?	☐ Yes	☒ No	☐ Unknown
Date of last retinal eye exam			
Was exam result negative? (i.e. showed that no retinopathy was present)	☐ Yes	☐ No	☐ Unknown
Do you have problems with your eyesight?	☐ Yes	☐ No	
Do you have problems with your mouth or teeth?	☐ Yes	☐ No	
Oral problem			

PULMONARY			
Have you had wheezing in the past 12 months?	☐ Yes	☒ No	☐ Unknown
Have you had exposure to secondhand tobacco smoke?	☐ Yes	☐ No	
Do you cough nearly every morning?	☐ Yes	☒ No	☐ Unknown
Do you produce sputum with your cough?	☐ Yes	☐ No	
For how many years have you coughed and/or produced sputum?			
Do you get short of breath at rest?	☐ Yes	☒ No	☐ Unknown
Do you get short of breath with mild exertion?	☐ Yes	☒ No	☐ Unknown
Have you had a spirometry test in the last 12 months?	☐ Yes	☐ No	☐ N/A
Date of last spirometry	☐ Unknown		
Member has known diagnosis of pulmonary fibrosis	☐ Yes	☐ No	☐ Unknown
Specify treatment for Pulmonary Fibrosis:	☐ Medication	☒ Managed by Specialist	☐ Unknown
	☐ Other		
Do you have shortness of breath, fever, and cough?	☐ Yes	☒ No	

SMOKING HISTORY			
Have you ever smoked tobacco?	☒ Yes	☐ No	
Do you currently smoke?	☐ Yes	☒ No	
How many packs per day did you or do you smoke?	☐ <1	☒ 1	☐ 2
	☐ >2		
At what age did you start smoking?	26		
If you have quit smoking, at what age did you quit?	45		
Total years smoking?	19		
Total pack-years smoking?	19		

ASSESSMENT	
☐ Dx: Night blindness	☐ Dx: Visual loss
☒ Dx: Pulmonary fibrosis	

RECOMMENDATIONS	
☐ Consider baseline spirometry	☐ H11: Encourage smoking cessation (for all current smokers)
☐ H17: Consider dental evaluation	☐ H56: Consider comprehensive eye exam
☐ D5: Consider dilated eye exam or referring to an ophthalmologist (diabetics)	

CARDIOVASCULAR

Cardiovascular Notes :

CARDIOVASCULAR			
Do you experience shortness of breath at night and/or when lying down (PND)?	☐ Yes	☒ No	☐ Unknown
When you exercise or do a physical activity, do you get too winded to continue? (exercise intolerance)	☐ Yes	☒ No	☐ Unknown
Have you ever had a heart attack (myocardial infarction)?	☐ Yes	☐ No	
When was your last heart attack?	☐ Unknown / Uncertain		
Have you had a coronary artery bypass (CABG) and/or stent placed?	☐ Yes	☒ No	☐ Unknown
Member has heart failure (systolic, diastolic, unspecified)	☒ Yes	☐ No	☐ Unknown
Member has liver cirrhosis	☐ Yes	☒ No	☐ Unknown
Does the patient have evidence of volume overload due to heart failure or cirrhosis (edema, weight gain attributed to HF/cirrhosis, chronic use of loop diuretic or aldosterone antagonist)?	☒ Yes	☐ No	☐ Unknown
Member has peripheral vascular (arterial) stent	☐ Yes	☒ No	☐ Unknown
Do you have pain, ache, discomfort or fatigue in your leg(s) with activity that is often relieved by rest (vascular claudication)?	☐ Yes	☒ No	☐ Unknown
Do you have an implanted defibrillator?	☐ Yes	☒ No	☐ Unknown
Do you have a pacemaker?	☐ Yes	☒ No	☐ Unknown
Do you experience a rapid, strong, or irregular heartbeat? (palpitations)	☐ Yes	☐ No	
Member has known diagnosis of atrial fibrillation	☐ Yes	☒ No	☐ Unknown
Does the member have at least one of the following criteria? (Select ALL that apply)	☐ Age <65	☐ Age 65-74	☐ Age ≥75
	☐ Diabetes	☐ Female	☐ Heart failure
	☐ Hypertension	☐ Vascular disease	☐ History of stroke/TIA/thromboembolism
CHADS2/VASc Score			
Do you experience pain, discomfort, or a pressure / heaviness in your chest? (Select Yes if present with or without treatment)	☐ Yes	☒ No	☐ Unknown

ANGINA SCREEN - ANSWERS REFLECT UNTREATED SYMPTOMS			
Do you get pain or discomfort when you walk uphill or hurry?	☐ Yes	☐ No	☐ Unknown
When you get any pain or discomfort in your chest, do you slow down or stop?	☐ Yes	☐ No	☐ Unknown
Does it go away when you stand still?	☐ Yes	☐ No	☐ Unknown
Does it go away in < 10 minutes?	☐ Yes	☐ No	☐ Unknown
Is the pain located in or near the left upper arm, left anterior chest, or sternum?	☐ Yes	☐ No	☐ Unknown
Angina Score (number of Yes responses)			

ASSESSMENT	
☐ Dx: Peripheral arterial disease (PAD)	☐ Dx: Arrhythmia
☐ Dx: Claudication, intermittent	☐ Dx: Old myocardial infarction (MI)
☐ Dx: Coronary artery disease	☐ Dx: Angina, pectoris
☐ Dx: Secondary hypercoagulable state	☒ Dx: Secondary hyperaldosteronism

RECOMMENDATIONS	
☐ H2: Consider further evaluation and management for hypertension	☐ H31: Consider further evaluation and management of vascular disease
☐ Recommend education/assistance for member with hypertension management	

GI/GU & MUSCULOSKELETAL

GI/GU Notes :

GASTROINTESTINAL

Do you experience excessive bloating after eating?	[X] Yes	[ ] No	[ ] Unknown
Member has chronic hepatitis (not acute)	[X] Yes	[ ] No	
Have you ever received treatment for chronic hepatitis?	[ ] Never treated	[ ] Previously treated and cured	[ ] Previously treated, not cured
	[ ] Currently under treatment	[ ] Unknown	
Do you have pain just below the rib cage (upper abdomen) that keeps coming back?	[ ] Yes	[ ] No	
Pain medications needed?	[ ] Yes	[ ] No	
Do you have malodorous, fatty stools?	[ ] Yes	[ ] No	
Do you experience reflux symptoms?	[ ] Yes	[ ] No	
Chronic constipation requiring treatment?	[X] Yes	[ ] No	

GASTROINTESTINAL ASSESSMENT

- [ ] Dx: Gastroparesis
- [ ] Dx: Regional enteritis (Crohn's)
- [ ] Dx: GERD
- [X] Dx: Constipation
- [ ] Dx: Ulcerative colitis
- [ ] Dx: Chronic pancreatitis
- [X] Dx: Chronic hepatitis

GENITOURINARY

Do you have difficulty with erections?	[ ] Yes	[X] No	[ ] Unknown	**In the past 6 months, have you accidentally leaked urine?**	[ ] Yes	[X] No	[ ] Unknown
Has your doctor spoken with you about ways to control or manage urine leakage?	[ ] Yes	[ ] No		**Is urine leakage affecting your sleep?**	[ ] Yes	[ ] No	
Do you have frequent UTIs?	[ ] Yes	[ ] No					

GENITOURINARY ASSESSMENT

- [ ] Dx: Erectile dysfunction
- [ ] Dx: Urinary incontinence
- [ ] Dx: Personal history of UTIs

MUSCULOSKELETAL

Have you experienced chronic joint pain for more than 2 months?	[ ] Yes	[ ] No
Have you experienced morning joint stiffness lasting at least an hour?	[ ] Yes	[ ] No
Are your joint symptoms improved with exercise?	[ ] Yes	[ ] No

MUSCULOSKELETAL ASSESSMENT

- [ ] Dx: Osteoarthritis

RECOMMENDATIONS

- [ ] H6: Consider urinary incontinence management program
- [ ] H57: Consider evaluation of history of chronic hepatitis
- [ ] H53: Consider evaluation of history of recent blood in stool

NEUROPSYCHIATRIC

Neuropsychiatric Notes :

NEUROPSYCHIATRIC

Do you get dizzy when you stand?	[ ] Yes	[ ] No		**Have you fainted or lost consciousness?**	[ ] Yes	[ ] No
Have you ever had a stroke (CVA)?	[ ] Yes	[X] No		**Residual stroke problems**	[ ] Yes	[ ] No
	[ ] Unknown				[ ] Unknown	
Residual stroke issues	[ ] Speech	[ ] Swallowing		**Have you ever had a TIA (transient ischemic attack)?**	[ ] Yes	[ ] No
	[ ] Paralysis	[ ] Cognition				
	[ ] Paresis	[ ] Other				
Do you have a seizure disorder?	[ ] Yes	[X] No		**Date of last seizure**		[ ] Unknown / Uncertain
	[ ] Unknown					

NEUROPSYCHIATRIC

Severity	☐ Mild	☐ Moderate	**During the past 12 months, have you fallen more than once or twice?**	☐ Yes	☐ No
	☐ Severe	☐ Unknown			
Have you had an injury associated with falls?	☐ Yes	☐ No	**During the past year, have you had a problem with balance or walking?**	☐ Yes	☐ No
Has your doctor spoken with you about falling or problems with balance or walking?	☐ Yes	☐ No	**Has your doctor done anything to help you prevent falls or improve your balance?**	☐ Yes	☐ No
Have you had polio?	☐ Yes	☐ No	**Osteopathy of polio (such as leg shortening, deformity of hip/knee/ankle/foot, scoliosis)**	☐ Yes	☐ No
Are your feet numb?	☐ Yes	☒ No	**Is leg pain/weakness helped by bending forward like you're pushing a shopping cart?**	☐ Yes	☐ No
	☐ Unknown				

REGULARLY EXPERIENCE ANY OF THE FOLLOWING

Stress	☐ Yes	☐ No
Anxiety, of such intensity, that it interferes with daily activities?	☐ Yes	☐ No

ASSESSMENT

- ☐ Dx: Spinal stenosis
- ☐ Dx: Anxiety disorder
- ☐ Dx: Osteopathy from poliomyelitis

RECOMMENDATIONS

- ☐ Talk to your PCP about ways to manage stress
- ☐ H5: Consider fall risk reduction program
- ☐ H9: Consider neuropsychiatric evaluation if significant behavioral issues
- ☐ H32: Consider further evaluation and management of lower extremity neurologic symptoms

ALCOHOL & DRUG USE

Alcohol & Drug Use Notes :

ALCOHOL USE SCREENING

How often do you have a drink containing alcohol?	☒ Never	☐ Monthly or less	☐ 2-4 times a month
	☐ 2-3 times a week	☐ 4 or more times a week	☐ Unknown
How many drinks containing alcohol do you have on a typical day when you drink?	☐ 1 or 2	☐ 3 to 4	☐ 5 to 6
	☐ 7 to 9	☐ 10 or more	☐ Unknown
How often do you have six or more drinks on one occasion?	☐ Never	☐ Less than monthly	☐ Monthly
	☐ Weekly	☐ Daily or almost daily	☐ Unknown
AUDIT-C score	0		
Do you have a past diagnosis of alcohol dependence or have you participated in an alcohol treatment program in the past?	☐ Yes	☒ No	
Alcohol used within last 3 months?	☐ Yes	☐ No	
Hazardous use: Have you used the substance in ways that are dangerous to yourself and/or others, i.e., overdosed, driven while under the influence, or blacked out?	☐ Yes	☐ No	☐ Unknown
Social or interpersonal problems related to use: Has substance use caused relationship problems or conflicts with others?	☐ Yes	☐ No	☐ Unknown
Neglected major roles to use: Have you failed to meet your responsibilities at work, school, or home because of substance use?	☐ Yes	☐ No	☐ Unknown
Withdrawal: When you stop using the substance, do you experience withdrawal symptoms?	☐ Yes	☐ No	☐ Unknown
Tolerance: Have you built up a tolerance to the substance so that you have to use more to get the same effect?	☐ Yes	☐ No	☐ Unknown
Used larger amounts/longer: Have you started to use larger amounts or use the substance for longer amounts of time?	☐ Yes	☐ No	☐ Unknown
Repeated attempts to control use or quit: Have you tried to cut back or quit entirely, but haven't been successful?	☐ Yes	☐ No	☐ Unknown
Much time spent using: Do you spend a lot of your time using the substance?	☐ Yes	☐ No	☐ Unknown
Physical or psychological problems related to use: Has your substance use led to physical health problems, such as liver damage or lung cancer, or psychological issues, such as depression or anxiety?	☐ Yes	☐ No	☐ Unknown
Activities given up to use: Have you skipped activities or stopped doing activities you once enjoyed in order to use the substance?	☐ Yes	☐ No	☐ Unknown
Craving: Have you experienced cravings for the substance?	☐ Yes	☐ No	☐ Unknown
Alcohol DSM V Score			
Are you actively participating in an alcohol treatment program?	☐ Yes	☐ No	☐ N/A

DRUG USE SCREENING

Are you using a medication or substance with a dependence potential (sedative/hypnotic, opioid, stimulant, etc.)?	☐ Yes	☒ No	☐ Unknown
Do you have a past diagnosis of substance dependence or have you participated in a drug treatment program in the past?	☐ Yes	☒ No	
Please specify past substance disorder	☐ Opioid	☐ Cocaine	☐ Other stimulant (not caffeine)
	☐ Sedative/hypnotic/anxiolytic	☐ Hallucinogen	☐ Inhalant
	☐ Cannabis	☐ Other	
Substance used within the past 3 months?	☐ Yes	☐ No	
Please specify the substance(s)in use	☐ Opioid	☐ Cocaine	☐ Other stimulant (not caffeine)
	☐ Sedative/hypnotic/anxiolytic	☐ Hallucinogen	☐ Inhalant
	☐ Cannabis	☐ Other	
Hazardous use: Have you used the substance in ways that are dangerous to yourself and/or others, i.e., overdosed, driven while under the influence, or blacked out?	☐ Yes	☐ No	☐ Unknown
Social or interpersonal problems related to use: Has substance use caused relationship problems or conflicts with others?	☐ Yes	☐ No	☐ Unknown
Neglected major roles to use: Have you failed to meet your responsibilities at work, school, or home because of substance use?	☐ Yes	☐ No	☐ Unknown
Withdrawal: When you stop using the substance, do you experience withdrawal symptoms?	☐ Yes	☐ No	☐ Unknown
Tolerance: Have you built up a tolerance to the substance so that you have to use more to get the same effect?	☐ Yes	☐ No	☐ Unknown
Used larger amounts/longer: Have you started to use larger amounts or use the substance for longer amounts of time?	☐ Yes	☐ No	☐ Unknown
Repeated attempts to control use or quit: Have you tried to cut back or quit entirely, but haven't been successful?	☐ Yes	☐ No	☐ Unknown
Much time spent using: Do you spend a lot of your time using the substance?	☐ Yes	☐ No	☐ Unknown
Physical or psychological problems related to use: Has your substance use led to physical health problems, such as liver damage or lung cancer, or psychological issues, such as depression or anxiety?	☐ Yes	☐ No	☐ Unknown
Activities given up to use: Have you skipped activities or stopped doing activities you once enjoyed in order to use the substance?	☐ Yes	☐ No	☐ Unknown
Craving: Have you experienced cravings for the substance?	☐ Yes	☐ No	☐ Unknown
Substance DSM V Score			
Are you actively participating in a drug treatment program?	☐ Yes	☐ No	☐ N/A

ASSESSMENT

- ☐ Dx: Alcohol dependence
- ☐ Dx: Alcohol abuse
- ☐ Dx: Substance dependence
- ☐ Dx: Alcohol dependence, in remission
- ☐ Dx: Substance dependence, in remission
- ☐ Dx: Substance abuse

RECOMMENDATIONS

- ☐ H10: Discourage alcohol or other drug use
- ☐ Consider follow up assessment of current alcohol/substance use for member with past history of substance use disorder

DEPRESSION SCREEN

Depression Screen Notes :

PERSISTENT MOOD DISORDER

Has the individual been on treatment (e.g. antidepressant, counseling) for more than a year for a mood disorder? OR Have they been bothered by feeling down, depressed, or hopeless for many years? OR Have they been bothered by little interest or pleasure in doing things for many years?	☐ Yes	☐ No

PHQ-4

	Not at all	Several days	More than half the days	Nearly every day	
Feeling nervous, anxious or on edge	☐ 0	☒ 1	☐ 2	☐ 3	☐ N/A
Not being able to stop or control worrying	☐ 0	☒ 1	☐ 2	☐ 3	☐ N/A
Anxiety Subscale Score	2				
Little interest or pleasure in doing things	☐ 0	☒ 1	☐ 2	☐ 3	☐ N/A
Feeling down, depressed, or hopeless	☐ 0	☒ 1	☐ 2	☐ 3	☐ N/A
Depression Subscale Score	2				
Note regarding N/A on PHQ-4					

ADJUSTMENT REACTION

Is current mood disorder related to an adjustment reaction (e.g. significant loss and/or event within the last 6 months)?	☐ Yes	☐ No

PHQ-9

	Not at all	Several days	More than half the days	Nearly every day
Had a poor appetite or overeaten?	☐ 0	☐ 1	☐ 2	☐ 3
Had trouble falling asleep, staying asleep or slept too much?	☐ 0	☐ 1	☐ 2	☐ 3
Felt tired or had little energy?	☐ 0	☐ 1	☐ 2	☐ 3
Felt bad about yourself, felt you were a failure, or felt you had let yourself or your family down?	☐ 0	☐ 1	☐ 2	☐ 3
Had trouble concentrating on things like reading or watching TV?	☐ 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
Thinking you would be better off dead or that you should hurt yourself in some way?	☐ 0	☐ 1	☐ 2	☐ 3
Current Severity Score				
Severity (today)				
Current Depressive Score				
If any PHQ-9 questions marked, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	☐ Not difficult at all	☐ Somewhat difficult	☐ Very difficult	☐ Extremely difficult

MAJOR DEPRESSIVE DISORDER (MDD)

Is major depressive disorder present on today's PHQ-9 screen?	☐ Yes	☐ No	☐ N/A
Has individual had repeated episodes of depression (at least 2 weeks of symptoms) separated by 2 months?	☐ Yes	☐ No	☐ Unknown

REMISSION STATUS WITH KNOWN HISTORY OF DEPRESSION

Has individual had recurrent episodes of depression (at least 2 months between episodes without major symptoms)?	☐ Yes	☐ No	☐ N/A	**Has individual's symptom free interval been short (< 2 months)?**	☐ Yes	☐ No	☐ N/A

SUICIDE RISK SCREENING

Member is able to answer suicide screening questions?	☐ Yes	☐ No	☒ Refused
Specify reason member is unable to answer screening questions			
Have you wished you were dead or wished you could go to sleep and not wake up?	☐ Yes	☐ No	
Have you actually had any thoughts of killing yourself?	☐ Yes	☐ No	
Have you been thinking about how you might do this?	☐ Yes	☐ No	
Have you had these thoughts and had some intention of acting on them?	☐ Yes	☐ No	
Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?	☐ Yes	☐ No	
Have you ever done anything, started to do anything, or prepared to do anything to end your life?	☐ Yes	☐ No	
Was this in the past three months?	☐ Yes	☐ No	
Suicide Risk Assessment	☐ Low	☐ Moderate	☐ High

MAJOR PSYCHIATRIC DISORDERS

Member has known diagnosis of bipolar disorder	☐ Yes	☐ No	
Member has known diagnosis of schizophrenia	☐ Yes	☐ No	
If applicable, specify treatment for Bipolar Disorder or Schizophrenia.	☐ Medications	☐ Counseling	☐ Member is noncompliant with treatment
	☐ Other		

ASSESSMENT

☐ Dx: Persistent mood disorder	☐ Dx: Adjustment disorder with depressed mood (grief)
☐ Dx: Mood disorder	☐ Dx: Depression
☐ Dx: Major depressive disorder, single episode, partial remission	☐ Dx: Major depressive disorder, single episode, full remission
☐ Dx: Major depressive disorder, single episode ☐ Mild ☐ Moderate ☐ Severe	☐ Dx: Major depressive disorder, recurrent, full remission

ASSESSMENT				
☐ Dx: Major depressive disorder, recurrent, partial remission	☐ Dx: Major depressive disorder, recurrent episode	☐ Mild	☐ Moderate	☐ Severe

RECOMMENDATIONS
☐ H16: Consider further evaluation and management of depression

ENDOCRINE

Endocrine Notes :

DIABETES			
Member has diabetes mellitus	☐ Yes	☒ No	☐ Unknown
Diabetes type	☐ Type 1	☐ Type 2	☐ Secondary
Cause of secondary diabetes	☐ Chronic steroid use	☐ Cushing's	☐ Hemochromatosis
	☐ Cystic fibrosis	☐ Chronic pancreatitis	☐ Acromegaly
	☐ Other		
How are you currently managing your diabetes?	☐ Diet/Exercise	☐ Medications (anti-diabetics)	☐ None
Have you been advised by your physician or other healthcare professional to treat your diabetes?	☐ Yes	☐ No	
In the last 6 months, have you had a blood sugar reading of < 70 mg/dl and/or one or more episodes of shaking, tremors, sweating, palpitations, drowsiness, confusion, seizures (potential hypoglycemia)?	☐ Yes	☐ No	

DIABETES ASSESSMENT				
☐ Dx: Diabetes with diabetic autonomic (poly) neuropathy				
☐ Dx: Diabetes with other circulatory complications				
☐ Dx: Other (diabetic) circulatory complications:	☐ Atherosclerosis	☐ CAD	☐ CVA	☐ Old MI
	☐ Angina pectoris	☐ Vascular-induced dementia	☐ Other	
☐ Dx: Diabetes with diabetic amyotrophy				
☐ Dx: Non-proliferative diabetic retinopathy				
☐ Dx: Proliferative diabetic retinopathy				

OSTEOPOROSIS SCREENING		
Have you had hip replacement surgery?	☐ Yes	☐ No
Member has kyphosis present	☐ Yes	☐ No
Have you lost 2 or more inches in height since age 20?	☐ Yes	☐ No

OSTEOPOROSIS SCREENING ASSESSMENT
☐ Dx: Osteoporosis

RECOMMENDATIONS	
☐ D7: Consider ACE inhibitor or ARB therapy (especially for diabetics)	☐ D13: Consider statin therapy (especially for diabetics)
☐ H3: Consider baseline or repeat evaluation for osteoporosis or medical therapy	

HEMATOLOGY/ONCOLOGY

Oncology Notes :

HEMATOLOGY/ONCOLOGY

Member has Sickle Cell or other coagulation defect	[X] Yes	[ ] No		
Specify sickle cell or other coagulation defect	[ ] Sickle cell	[ ] Hemophilia	[X] Factor V deficiency	[X] Factor V Leiden mutation
	[ ] Other			
Specify treatment	test			
Member has been diagnosed with a condition other than HIV causing an immunocompromised state	[ ] Yes	[X] No	[ ] Unknown	
Specify condition				
Member is taking a medication/drug that would cause immunosuppression	[ ] Yes	[X] No	[ ] Unknown	
Specify medication/drug (please ensure drug is documented in medication section)				
Member is impacted by an external factor that would cause immunosuppression, ie radiation therapy	[ ] Yes	[X] No	[ ] Unknown	
Specify external factor				
Member has been diagnosed previously with basal cell and/or localized squamous cell carcinoma	[ ] Yes	[ ] No		
Member has been diagnosed previously with other cancer	[ ] Yes	[ ] No		

ADDITIONAL DETAIL (OF MOST RECENT MAJOR PRIMARY MALIGNANCY)

Date of initial cancer diagnosis				
Primary Site (of most recent cancer)	[ ] Bladder	[ ] Brain	[ ] Breast	[ ] Cervical
	[ ] Colon	[ ] Kidney	[ ] Leukemia	[ ] Liver
	[ ] Lung	[ ] Lymphoma	[ ] Melanoma	[ ] Ovary
	[ ] Pancreas	[ ] Prostate	[ ] Uterine	[ ] Unknown
	[ ] Other			
Is your cancer in remission?	[ ] Yes	[ ] No	[ ] N/A	
Years in remission				
Has your cancer metastasized?	[ ] Yes	[ ] No	[ ] N/A	
Metastatic site(s)	[ ] Bone	[ ] Brain	[ ] Liver	[ ] Lung
	[ ] Skin	[ ] Unknown	[ ] Other	

CANCER TREATMENT

Cancer treatment status	[ ] Ongoing adjunctive treatment (e.g., tamoxifen, Herceptin, Lupron)	[ ] Ongoing treatment (chemotherapy, radiation, surgery)	[ ] Ongoing treatment, but specifics unknown	[ ] Palliative approach
	[ ] Treatment completed	[ ] Treatment pending or on hold (plan being revisited)	[ ] Treatment refused	[ ] Treatment status unknown
	[ ] Other			

ASSESSMENT

- [ ] Dx: Sickle cell
- [ ] Dx: Hemophilia
- [X] Dx: Factor V deficiency
- [X] Dx: Factor V Leiden mutation
- [ ] Dx: Immunodeficiency due to specified condition
- [ ] Dx: Immunodeficiency due to drugs
- [ ] Dx: Immunodeficiency due to external factors

RECOMMENDATIONS

- [ ] H1: Consider Advanced Care planning, including DNR, Advance Directive, Living Will, Medical Power of Attorney
- [ ] H33: Consider hospice or palliative care discussion or referral
- [ ] Recommend assistance for member with symptoms associated with cancer or cancer treatment

Vitals, Artificial Openings, & Devices

Vitals, Artificial Openings, & Devices Notes :

GENERAL APPEARANCE & STATION

General appearance and station	[X] Normal	[ ] Ill appearing	[ ] Bedbound	[ ] Wheelchair dependent
	[ ] Cachexic	[ ] Massively overweight	[ ] Down syndrome facies	[ ] Other
Assess level of consciousness along a continuum	[ ] Alert	[ ] Drowsy	[ ] Stuporous	[ ] Comatose
Height (ft)				
Height (in)				
Height was measured today	[ ] Yes	[ ] No		
Weight (lbs)				
Weight was measured today	[ ] Yes	[ ] No		
BMI				
Does the member have comorbid conditions?	[ ] Yes	[ ] No		
Select all that apply:	[ ] COPD	[ ] Diabetes	[ ] Hypertension	[ ] Cardiovascular disease (CHF, venous stasis, atherosclerosis, h/o MI)
	[ ] Obstructive Sleep Apnea	[ ] Osteoarthritis, weight-bearing joints		

MALNUTRITION SCREENING

Have you recently (within the last 6 months) lost weight without being on a diet or wanting to lose weight?	[ ] Yes	[ ] No	**How much weight have you lost? (lbs)**		
% of weight lost			**Member has an empty refrigerator (< 3 different food products)**	[ ] Yes	[ ] No
Inadequate food intake (inability to consume or obtain food)	[ ] Yes	[ ] No	**Do you eat fewer than 2 full meals a day?**	[ ] Yes	[ ] No
Do you eat 2 or more servings of fruit or vegetables a day?	[ ] Yes	[ ] No			

GENERAL APPEARANCE & STATION ASSESSMENT

[ ] Dx: Underweight
[ ] Dx: Overweight
[ ] Dx: Obesity
[ ] Dx: Morbid obesity

BLOOD PRESSURE (BP)

Blood pressure (supine) -- / --	**Blood pressure (sitting)** -- / --	**Blood pressure (standing)** -- / --	**Repeat blood pressure reading** -- / --
[ ] **Unable to obtain supine blood pressure**	[ ] **Unable to obtain sitting blood pressure**	[ ] **Unable to obtain standing blood pressure**	

BLOOD PRESSURE TRIAGE

Member has evidence of end organ damage:	[ ] Yes	[ ] No	[ ] Unknown	
Suspected acute end organ damage:	[ ] Acute MI	[ ] Angina	[ ] Dissection	[ ] Encephalopathy
	[ ] Heart failure	[ ] Intracerebral hemorrhage	[ ] Papilledema/Retinopathy	[ ] Pulmonary edema
	[ ] Other			
Hypertensive interpretation:	[ ] Elevated blood pressure	[ ] Hypertensive (Stage 1)	[ ] Hypertensive (Stage 2)	[ ] Severe hypertension without end organ damage
	[ ] Severe hypertension with end organ damage			

BLOOD PRESSURE ASSESSMENT

[ ] Dx: Elevated blood pressure reading
[ ] Dx: Orthostatic hypotension
[ ] Dx: Hypertensive crisis

PULSE

Pulse (supine)		**Pulse (sitting)**			
Pulse (standing)		**Heart rhythm**	[ ] Regular	[ ] Irregular	[ ] Irregularly irregular	[ ] Unable to obtain pulse
Member experiences dizziness when standing	[ ] Yes [ ] No	**Pulse oximetry SpO2 (%)**			

ARTIFICIAL OPENINGS AND DEVICES

Devices:	[ ] Ileostomy	[ ] Colostomy	[ ] Gastrostomy	[ ] Cystostomy
	[ ] CPAP/BiPAP	[ ] Tracheostomy	[ ] Other	

VITALS & DEVICES ASSESSMENT	
☐ Dx: Cachexia	☐ Dx: Persistent vegetative state
☐ Dx: Comatose	☐ Dx: Trisomy 21 (Down syndrome)
☐ Dx: Hypoxemia	☐ Dx: Autonomic neuropathy
☐ Dx: Arrhythmia	☐ Dx: Sleep apnea
☐ Dx: Status post amputation	☐ Dx: Dependence on ventilator
☐ Dx: Chronic respiratory failure	☐ Dx: Malnutrition

RECOMMENDATIONS	
☐ H5: Consider fall risk reduction program	☐ H2: Consider further evaluation and management for hypertension
☐ H13: Consider weight screening (BMI)	☐ D8: Consider counseling to manage weight (diabetics)

INTEGUMENT & MUSCULOSKELETAL

Integument & Musculoskeletal Notes :

INTEGUMENT & MUSCULOSKELETAL				
Chronic pressure ulcer (injury)	☐ Absent	☐ Present		
Specify site(s) of chronic pressure ulcers, Stage 1: Non-blanchable erythema, intact skin	☐ Ankle	☐ Buttock	☐ Elbow	☐ Head
	☐ Heel	☐ Hip	☐ Lower back	☐ Sacral
	☐ Upper back			
Specify site(s) of chronic pressure ulcers, Stage 2: Partial thickness loss of skin with exposed dermis	☐ Ankle	☐ Buttock	☐ Elbow	☐ Head
	☐ Heel	☐ Hip	☐ Lower back	☐ Sacral
	☐ Upper back			
Specify site(s) of chronic pressure ulcers, Stage 3: Full thickness loss of skin	☐ Ankle	☐ Buttock	☐ Elbow	☐ Head
	☐ Heel	☐ Hip	☐ Lower back	☐ Sacral
	☐ Upper back			
Specify site(s) of chronic pressure ulcers, Stage 4: Full thickness loss of dermis with exposed bone, tendon	☐ Ankle	☐ Buttock	☐ Elbow	☐ Head
	☐ Heel	☐ Hip	☐ Lower back	☐ Sacral
	☐ Upper back			
Specify site(s) of chronic pressure ulcers, Stage: Deep tissue injury	☐ Ankle	☐ Buttock	☐ Elbow	☐ Head
	☐ Heel	☐ Hip	☐ Lower back	☐ Sacral
	☐ Upper back			
Specify site(s) of chronic pressure ulcers, Stage: Unstageable, full thickness loss of dermis, depth unknown	☐ Ankle	☐ Buttock	☐ Elbow	☐ Head
	☐ Heel	☐ Hip	☐ Lower back	☐ Sacral
	☐ Upper back			
Specify site(s) of chronic pressure ulcers, Stage: Unspecified	☐ Ankle	☐ Buttock	☐ Elbow	☐ Head
	☐ Heel	☐ Hip	☐ Lower back	☐ Sacral
	☐ Upper back			
Chronic non-pressure ulcer (injury)	☐ Absent	☐ Present		
Specify site(s) of chronic non-pressure ulcers, severity: Break down of skin only	☐ Arm	☐ Ankle	☐ Buttock	☐ Elbow
	☐ Foot	☐ Forearm	☐ Hand	☐ Head
	☐ Heel	☐ Hip	☐ Lower back	☐ Lower leg
	☐ Pelvis	☐ Sacral	☐ Toes	☐ Trunk
	☐ Upper back	☐ Upper leg		
Specify site(s) of chronic non-pressure ulcers, severity: Fat layer exposed	☐ Arm	☐ Ankle	☐ Buttock	☐ Elbow
	☐ Foot	☐ Forearm	☐ Hand	☐ Head
	☐ Heel	☐ Hip	☐ Lower back	☐ Lower leg
	☐ Pelvis	☐ Sacral	☐ Toes	☐ Trunk
	☐ Upper back	☐ Upper leg		

INTEGUMENT & MUSCULOSKELETAL

Specify site(s) of chronic non-pressure ulcers, severity: Necrosis of bone	☐ Arm	☐ Ankle	☐ Buttock	☐ Elbow
	☐ Foot	☐ Forearm	☐ Hand	☐ Head
	☐ Heel	☐ Hip	☐ Lower back	☐ Lower leg
	☐ Pelvis	☐ Sacral	☐ Toes	☐ Trunk
	☐ Upper back	☐ Upper leg		
Specify site(s) of chronic non-pressure ulcers, severity: Unspecified	☐ Arm	☐ Ankle	☐ Buttock	☐ Elbow
	☐ Foot	☐ Forearm	☐ Hand	☐ Head
	☐ Heel	☐ Hip	☐ Lower back	☐ Lower leg
	☐ Pelvis	☐ Sacral	☐ Toes	☐ Trunk
	☐ Upper back	☐ Upper leg		
Dermatitis	☒ Absent	☐ Present		
Site(s) of Dermatitis	☐ Head/Neck	☐ Trunk	☐ Limbs	
Lower extremity venous stasis and/or venous insufficiency	☒ Absent	☐ Present	☐ Unable to assess	
Inflammation	☐ Absent	☐ Present		
Unilateral extremity edema	☐ Absent	☐ Present		
Bilateral extremity edema	☐ Absent	☐ Present		
Venous engorgement	☐ Absent	☐ Present		
Cutaneous cyanosis in dependent extremity	☐ Absent	☐ Present		
Amputation	☒ Absent	☐ Present		
Ulnar deviation of digits	☐ Absent	☐ Present		
Synovitis (swelling)	☐ Absent	☐ Present		
Ten or more joints involved in inflammatory process	☐ Absent	☐ Present		
Member has autoimmune condition	☐ Yes	☒ No	☐ Unknown	
Specify autoimmune condition	☐ Rheumatoid Arthritis	☐ Polymyalgia rheumatica	☐ Lupus (SLE)	☐ Sacroiliitis
	☐ Other			
Member's autoimmune condition is treated with DMARD or other biologic	☐ Yes	☐ No	☐ Unknown	
Reason DMARD or other biologic not in use?	☐ Unable to tolerate	☐ Member refuses	☐ Other	
Specify treatment	☐ Other Rx (e.g., steroid, NSAID)	☐ Palliative (e.g., warm soaks, yoga, rheumatoid tea)	☐ Under care of clinician	☐ Other

ASSESSMENT

☐ Dx: Chronic venous thrombosis of deep veins of lower extremity	☐ Dx: Chronic venous hypertension of lower extremity
☐ Dx: Chronic venous hypertension with ulcer(s)	☐ Dx: Atherosclerosis, extremity with ulcer(s)
☐ Dx: Atherosclerosis, extremity without ulcer(s)	☐ Dx: Diabetic ulcer
☐ Dx: Phantom limb syndrome	☐ Dx: Phantom limb syndrome with pain
☐ Dx: Neuroma of amputation stump	☐ Dx: Chronic infection of amputation stump
☐ Dx: Status post amputation	☐ Dx: Other complication of amputation
Complication of amputation, specify	☐ Dx: Rheumatoid arthritis
☐ Dx: Polymyalgia rheumatica	☐ Dx: Lupus (SLE)
☐ Dx: Sacroiliitis	

RECOMMENDATIONS

☐ H5: Consider fall risk reduction program	☐ Evaluate for proper footwear. Consider podiatry evaluation (diabetics)
☐ H55: Consider further evaluation of peripheral vascular disease (PVD)	☐ R2: Consider DMARD for rheumatoid arthritis management
☐ Consider education/assistance with ulcer management	☐ Consider education/assistance with non-healing surgical wound

HEENT

Ocular external exam and anterior segment	☒ Normal	☐ Abnormal	☐ Unable to assess

HEENT

Specify abnormal ocular exam finding	☐ Icterus	☐ Conjunctival inflammation	☐ Arcus senilis
	☐ Cataract	☐ Other ocular issue	
Hearing screen (finger rub) [perform with hearing aids, if available, in place]	☐ Normal	☐ Abnormal	
Hearing loss	☐ Hearing loss on right	☐ Hearing loss on left	

THORAX

Thorax exam (Normal: chest symmetric with normal AP dimension)	☐ Normal	☐ Abnormal	**Specify abnormal thorax exam finding**	☐ Hyperexpansion (barrel chest)	☐ Asymmetric	☐ Other thoracic issue

PULMONARY

Lung exam (Normal: normal effort and expansion, clear breath sounds bilaterally without crackles, rhonchi or wheezing, normal E/I ratio)	☒ Normal	☐ Abnormal	☐ Not performed
Reason lung exam not performed	☐ Member refused	☐ Other	
Specify abnormal lung exam finding	☐ Labored respiration	☐ Wheezing	☐ Rhonchi
	☐ Crackles	☐ Prolonged E/I Ratio	☐ Other lung issue

ORAL

Condition of dentition	☐ Normal	☐ Abnormal	**Periodontal disease**	☐ Absent	☐ Present
Repaired cleft lip and/or palate	☐ Absent	☐ Present			

ASSESSMENT

☐ Dx: Cataract	☐ Dx: Edentulism, partial
☐ Dx: Edentulism, complete	☐ Dx: Cleft lip
☐ Dx: Cleft palate	☐ Dx: Asthma
☐ Dx: Chronic bronchitis	☐ Dx: Emphysema
☐ Dx: COPD	☐ Dx: Chronic obstructive asthma
☐ Dx: Vocal cord dysfunction	

RECOMMENDATIONS

☐ H17: Consider dental evaluation	☐ P2: Consider further evaluation of pulmonary signs and symptoms
☐ C1: Consider oxygen therapy	☐ H59: Consider hearing evaluation

Frailty & Cardiovascular Notes :

TIMED GET UP AND GO

Member can perform timed get up and go	☐ Yes	☐ No	**Get up and go time to perform (seconds)**	**Timed get up and go**	☐ Normal	☐ Abnormal

FRAILTY ASSESSMENT

Level of physical activity	☐ High	☐ Moderate	☐ Low	**Hand grip strength**	☐ Strong	☐ Moderate	☐ Weak
Do you feel tired or exhausted most of the time?	☐ Yes	☐ No		**Get up and go time to perform (seconds)**	☐ <= 10 seconds	☐ > 10 seconds	
Unintentional weight change in the last year	☐ < 10 pounds	☐ >= 10 pounds		**Frailty Score**			

CARDIOVASCULAR

Heart exam (Normal: normal rate, regular rhythm, no gallop, murmur, rub, or JVD, non-displaced apex)	☒ Normal	☐ Abnormal	☐ Not performed
Reason heart exam not performed	☐ Member refused	☐ Other	
Specify abnormal heart exam finding	☐ Jugular venous distension (JVD)	☐ Murmur	☐ Gallop
	☐ Cardiomegaly	☐ Rub	☐ Rate
	☐ Rhythm	☐ Other heart issue	
Murmur Specify	☐ Systolic	☐ Diastolic	
Specify Grade for Murmur	☐ Grade 1 - audible on listening very carefully	☐ Grade 2 - faint	☐ Grade 3 - loud
	☐ Grade 4 - loud with palpable thrill	☐ Grade 5 - loud with stethoscope just touching the chest with palpable thrill	☐ Grade 6 - loud with stethoscope off the chest with palpable thrill
Pedal pulses	☒ Normal	☐ Abnormal	☐ Not performed
Reason pedal pulses not performed	☐ Member refused	☐ Other	

CARDIOVASCULAR

Bruit, carotid	☐ Absent	☐ Present	
Peripheral edema	☒ Absent	☐ Present	☐ Unable to assess
Edema, right	☐ 0	☐ 1+	☐ 2+
	☐ 3+	☐ 4+	☐ Unable to assess
Edema, left	☐ 0	☐ 1+	☐ 2+
	☐ 3+	☐ 4+	☐ Unable to assess

FRAILTY & CV ASSESSMENT

☐ Dx: Abnormality of gait
☐ Dx: Heart failure (CHF)
☐ Dx: Frailty

RECOMMENDATIONS

☐ H5: Consider fall risk reduction program
☐ F1: Consider ACE inhibitor or ARB (heart failure)
☐ F2: Consider diuretic in treatment of heart failure
☐ F3: Consider beta blocker in treatment of heart failure
☐ F6: Consider recommending a sodium restricted diet (CHF)

Abdomen Notes :

ABDOMEN

Enlarged liver	☒ Absent	☐ Present	**Liver span (cm)**		
Bruit, femoral	☐ Absent	☐ Present	**Bruit, abdominal**	☐ Absent	☐ Present
Pulsatile abdominal mass	☐ Absent	☒ Present	**Estimated size of pulsatile abdominal mass (cm)**	19	
Ascites	☐ Absent	☐ Present	**Jaundice**	☐ Absent	☐ Present

ASSESSMENT

☐ Dx: Hepatomegaly
☐ Dx: Atherosclerosis of aorta
☒ Dx: Abdominal aortic aneurysm (AAA)
☒ Dx: Chronic hepatitis
☐ Dx: Cirrhosis

RECOMMENDATIONS

☐ H41: Consider abdominal aortic aneurysm screening

COGNITIVE IMPAIRMENT SCREEN

Cognitive Impairment Screen Notes :

COGNITIVE IMPAIRMENT SCREEN

Member experiences memory loss that significantly interferes with daily activities	☐ Yes	☐ No	**Able to perform Mini-Cog (e.g., not able if comatose or otherwise unable to communicate or draw)**	☐ Yes	☒ No
				☐ Refused	

MINI-COG

Number of words recalled:	☐ 0	☐ 1	**CDT interpretation**	☐ Normal	☐ Abnormal
	☐ 2	☐ 3		☐ Refused	
Mini-Cog Score					

ASSESSMENT

☐ Dx: Cognitive impairment, mild
☐ Dx: Dementia
☐ Member exhibits a behavioral disturbance ☐ Yes ☐ No
☐ Specify behavioral disturbance ☐ Wandering ☐ Combative ☐ Aggression/agitation
☐ Other
☐ Dx: Senile psychosis
☐ Dx: Cerebral atherosclerosis

RECOMMENDATIONS
☐ H27: Consider further evaluation and management of dementia / memory impairment

NEUROLOGIC

Neurologic Notes :

NEUROLOGIC				
Affect	☐ Appropriate	☐ Inappropriate	☐ Flat	☐ Labile
	☐ Angry	☐ Sad		
Indicate dominant side (handedness)	☐ Left	☐ Right	☐ N/A	
Speech	☐ Normal	☐ Abnormal		
Facial asymmetry (weakness):	☐ Normal	☐ Abnormal - Left	☐ Abnormal - Right	☐ Abnormal - Bilateral
Member has normal pressure hydrocephalus	☐ Yes	☐ No		
Hydrocephalus management	☐ Shunt	☐ Other		
Monofilament sensation (multiple locations tested on each extremity):	☐ Normal	☒ Abnormal - Left	☐ Abnormal - Right	☐ Abnormal - Bilateral
	☐ Unable to perform due to physical or other limitation	☐ Member refused		
Position sense (great toe or ankle)	☒ Normal	☐ Abnormal - Left	☐ Abnormal - Right	☐ Abnormal - Bilateral
	☐ Unable to assess			
Vibratory sense	☒ Normal - Left	☐ Normal - Right	☐ Abnormal-Left	☐ Abnormal-Right
	☐ Unable to assess - Left	☐ Unable to assess - Right		
Ankle reflex:	☒ Normal	☐ Abnormal - Left	☐ Abnormal - Right	☐ Abnormal - Bilateral
	☐ Unable to assess			
Knee reflex:	☒ Normal	☐ Abnormal - Left	☐ Abnormal - Right	☐ Abnormal - Bilateral
	☐ Unable to assess			
Tremor	☐ Absent	☐ Present		
Tremor type	☐ Intention	☐ Resting		
Movement disorder	☐ Absent	☐ Present		
Movement disorder detail	☐ Ataxia	☐ Cogwheeling	☐ Congenital / infantile	☐ Difficulty with balance
	☐ Dyskinesia	☐ Festination	☐ Flattened facies	☐ Rigidity / bradykinesia
	☐ Trouble getting out of a chair	☐ Other		
Muscle atrophy	☐ Absent	☐ Present		

PARESIS/PARALYSIS REVIEW		
Paralysis or Paresis, limb	☒ Absent	☐ Present
	☐ Unknown	
Etiology of paresis or paralysis	☐ ALS	☐ Multiple sclerosis
	☐ Muscular dystrophy	☐ Myasthenia gravis
	☐ Polio	☐ Peripheral neuropathy
	☐ Rheumatologic or Autoimmune disorders	☐ Spinal cord injury
	☐ Stroke (CVA)	☐ Unknown
	☐ Other	
Indicate areas of any paralysis or paresis	☐ Upper - Left	☐ Upper - Right
	☐ Lower - Left	☐ Lower - Right

ASSESSMENT			
☐ Plegia/paresis Dx:	☐ Quadriplegia / paresis	☐ Triplegia / paresis	☐ Dx: Cerebral palsy
	☐ Paraplegia / paresis	☐ Diplegia / paresis	
	☐ Hemiplegia / paresis	☐ Monoplegia / paresis	
☐ Dx: Multiple sclerosis			☐ Dx: Normal Pressure Hydrocephalus
☐ Dx: Parkinson's Disease			☐ Dx: Parkinsonism

ASSESSMENT	
☐ Dx: Parkinsonism, secondary	☒ Dx: Peripheral neuropathy

RECOMMENDATIONS	
☐ H5: Consider fall risk reduction program	☐ H9: Consider neuropsychiatric evaluation if significant behavioral issues
☐ Consider assistance/education with multiple sclerosis management	☐ Multiple Sclerosis impacting ADLs, consider assistance with resources
☐ Parkinson's disease impacting ADLs, consider assistance with resources	

CASE MANAGEMENT NON-URGENT

Case Management - Non-urgent Notes :

CASE MANAGEMENT NON-URGENT		
Examiner, would you like to refer the member to non-urgent case management?	☐ Yes	☐ No

ISSUE(S)
☐ Behavioral health - Undiagnosed or untreated mental health issue, inability to obtain or tolerate prescribed psychotropic medications, newly diagnosed alcohol or drug dependence, or a household member who is difficult to manage
☐ Financial need - Financial need limiting food choices, basic necessities like water, sewer or utilities or ability to obtain medication
☐ Home safety - Home safety issue creating a health hazard (lack of adequate heating or cooling, infestation, fire hazard). Lack of caregiver/isolation. Cognitive impairment. Issues performing ADLs or IADLs.
☐ Non-compliance - Compliance (medication or DME) limited by finances, access, denial, cognitive issues, lack of understanding
☐ PCP Access - No known PCP or poor access to primary care due to reasons such as poor transportation, unrecognized need for primary care, inability to afford copay
☐ Transportation - Transportation issue limiting access to health care (PCP, pharmacy) or food
☐ Fall risk - Increased fall risk secondary to environmental issues, medication side effect, lack of ambulation aid, or disease process
☐ Other case management issue:

ACCEPTANCE		
Member/caregiver agrees to health plan case manager call back?	☐ Agrees	☐ Does NOT Agree

CASE MANAGEMENT URGENT

Case Management - Urgent Notes :

CASE MANAGEMENT URGENT		
An urgent or emergent clinical problem was found during today's assessment.	☐ Yes	☒ No

RECOMMENDATION			
An urgent or emergent clinical problem was found and the individual or caregiver was asked to:	☐ Go to an emergency department	☐ Visit an urgent care center	☐ Contact their PCP for an appointment or further instructions
	☐ Keep an existing appointment	☐ Other	

URGENCY			
Urgency	☐ STAT	☐ Today	☐ Within a week

UNDERSTANDING		
The member/caregiver's understanding of the issue	☐ Understands the recommendation & urgency	☐ Does not understand the recommendation & urgency

ACCEPTANCE / ASSISTANCE		
The acceptance of the recommendation is:	☐ Recommendation accepted	☐ Recommendation refused

ACTION			
Action taken at the time of the evaluation	☐ 911 called for emergency transport	☐ Other transportation arranged	☐ APS or CPS contacted
	☐ Discussed with PCP office	☐ Contacted Signify Health coordinator	☐ Other

ISSUE(S)
☐ Elevated blood pressure (with confusion, papilledema, angina or other significant finding induced by the hypertension)
☐ Low blood pressure (with marked orthostatic changes, dizziness or other significant finding induced by the hypotension needing acute intervention)
☐ New onset severe pain (e.g., r/o MI, thromboembolism, acute DVT, acute abdomen)
☐ Abnormal blood sugar (causing acute symptoms)
☐ New onset, acute dyspnea
☐ Medication problem (e.g., severe side effects, interacting drugs, duplicated drugs causing side effects and potential acute health effects, allergy)

ISSUE(S)
☐ Acute change in mental status or other new neurologic finding
☐ Severe depression, not under management, or with active suicide plan
☐ Suspicion of adult or child abuse
☐ Other urgent or emergent issue:
☐ Newly discovered diagnosis (or finding) in need of urgent medical attention, specify:

SUMMARY

Summary Notes :

SUMMARY		
CLINICAL COMPLEXITY: Using your clinical judgment, please indicate your overall assessment of this individual's clinical complexity.	☐ Not complex	☐ Complex
SOCIOECONOMIC COMPLEXITY: Using your clinical judgment, please indicate your overall assessment of this individual's socioeconomic complexity.	☐ Not complex	☐ Complex
Based on my assessment today, the individual	☐ Appears clinically stable on current management plan	☐ Follow up, as indicated by my recommendations, might be helpful
PCP Communication		

PLAN

Plan Notes :

PLAN NOTES
☐ P1: Plan notes were discussed with the member

LEAVE BEHIND

Leave Behind Notes :

YOUR MEDICATION PLAN:	
☐ Talk to your doctor about aspirin	☐ Go over your medications with your personal doctor or pharmacist
☐ Figure out a way to make it easier to take your medicine. Ask your doctor, pharmacist, or health plan for help	

STAY UP TO DATE ON YOUR VACCINES:	
☐ Go over your vaccination plan with your doctor (yearly)	☒ Flu vaccine (yearly)
☐ Pneumonia vaccine	☐ Shingles (once or twice after age 50)
☐ Tetanus / diphtheria / pertussis (Tdap) (every 10 years)	☐ Hepatitis vaccine (if needed)

TALK TO YOUR DOCTOR ABOUT THESE IMPORTANT HEALTH SCREENINGS:	
☐ Complete eye exam	☐ Blood screening
☐ Bone density screening	☐ Colorectal cancer screening
☐ Breast cancer screening and/or counseling (especially for women with a positive family history)	☐ Dental exam

TIPS FOR GENERAL HEALTH AND WELLNESS:	
☐ Monitor blood pressure if it is higher than normal	☐ Talk about bladder control problems with your doctor
☐ Create a Living Will to plan ahead	☐ Find new ways to improve your eating habits, increase your activity level, and maintain your weight

IF YOU HAVE DIABETES OR ARE AT RISK FOR DIABETES, TALK TO YOUR DOCTOR ABOUT THE FOLLOWING:	
☐ Testing for A1c, cholesterol, and kidney health	☐ Medicine that might help your kidneys (ACEi, ARB)
☐ Medicine to lower your cholesterol (statins)	☐ Nerve screening (yearly)
☐ A diabetes self-management program (yearly)	☐ Scheduling an eye exam (yearly)

IF YOU HAVE HEART FAILURE, TALK TO YOUR DOCTOR ABOUT THE FOLLOWING:
☐ Medications that might help (diuretics, ACEi, ARB)

FALL RISK-- HOW TO PREVENT A FALL:	
☐ Add more lighting so you can see obstacles on the floor	☐ Add hand rails in hallways and / or bathrooms
☐ Put non-skid material under loose rugs or remove them entirely	☐ Consider making it easier to access your home by adding a ramp or a railing

FALL RISK-- HOW TO PREVENT A FALL:
☐ Consider a fall reduction program and talk to your personal doctor about ways to prevent falls

TOBACCO USE:	
☐ Participate in a program to help you stop smoking. Your doctor or health plan can get you started	☒ Talk to your doctor about lung cancer screening

SAFE DRUG DISPOSAL	
☐ Two local locations where the member can safely dispose of medication was written on the paper leave behind during the visit.	Member local drug disposal locations

OTHER		
If other significant discussions, please specify	☐ None	☐ Comment

DX SUMMARY

Diagnosis Summary Notes :

DX SUMMARY	
PAGE	**DX GROUP**
Dx: Abdominal aortic aneurysm (AAA)	Abdominal aortic aneurysm
Dx: Chronic hepatitis	Chronic Hepatitis
Dx: Constipation	Constipation
Dx: Factor V deficiency	Factor V deficiency
Dx: Factor V Leiden mutation	Factor V Leiden mutation
Dx: Peripheral neuropathy	Peripheral neuropathy
Dx: Pulmonary fibrosis	Pulmonary fibrosis
Dx: Secondary hyperaldosteronism	Secondary hyperaldosteronism
Member has heart failure (systolic, diastolic, unspecified)	Heart failure

SIGNATURE

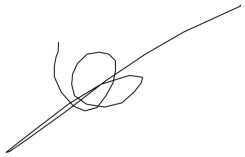
Signature Notes:

SIGNATURE			
Status	☐ Mobile transcription	☒ Completed	☐ Cancelled
Please identify why the visit is being transcribed:	☐ Member was not on my schedule	☐ iPad ran out of battery	☐ Other
Cancellation Reason	☐ Member Refused	☐ Member Requests Reschedule	☐ COVID-19 Risk Factors
	☐ Other	☐ Member does not have adequate technology	
Cancellation Reason Notes			
Cancellation Reason, specify			
Is the member or caregiver able and willing to sign the evaluation?	☒ Yes	☐ No	
Why is member/caregiver unable to sign?	☐ Member/caregiver physically unable to sign	☐ Member/caregiver refused to sign	☐ Other
Signature and name are the member's? If no, assure the signer is a qualified caregiver (POA,spouse, child)	☐ Yes	☐ No	☐ N/A

I understand that, pursuant to my prior informed consent, a clinician from Signify Health performed an evaluation of my current health status and provided me with a Personal Health Assessment, Recommendations and Screening Schedule. I also understand that the clinician performing today's evaluation is not assuming and has not assumed responsibility for my medical care. I should direct questions about my medical care to my own health care provider or I should call 911 in case of an emergency. The information obtained today and any applicable lab results (some of which may become available after subsequent analysis) may be sent to my primary care physician (PCP) or myself, if requested.

I have received drug disposal instructions and local locations.

Member's or caregiver's full signature



Date: 08/30/2022

Carroll, Titus

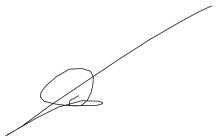
☐ Examiner, please check to confirm that member has been informed of the above statement

☐ Examiner, when urine or blood collected, confirm the member understands that the results will be sent to their PCP.

My signature attests that the medical record entries are accurate and complete to the best of my knowledge. This information was collected during a face-to-face encounter with the member and a medical chart review when applicable. I understand that any falsification may subject me to administrative, civil or criminal liability.

I attest verbal education and written information were provided to the member/responsible party regarding safe disposal of medications and drug take back programs per CMS criteria.

Examiner's Full Signature



Date: 08/30/2022

Digitally signed by Sindhu Silveru, M.D. Date 08/30/2022 03:06:21 PM

MAHC 10 - Fall Risk Assessment Tool

Required Core Elements **Asses one point for each core element "yes".** Information may be gathered from medical record, assessment and if applicable, the patient/caregiver. Beyond protocols listed below, scoring should be based on your clinical judgment.	Points
Age 65+	0
Diagnosis (3 or more co-existing) Includes only documented medical diagnosis.	1
Prior history of falls within 3 months An unintentional change in position resulting in coming to rest on the ground or at a lower level.	0
Incontinence Inability to make it to the bathroom or commode in timely manner. Includes frequency, urgency, and/or nocturia.	0
Visual impairment Includes, but not limited to, macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, accommodation, glare tolerance, depth perception, and night vision or not wearing prescribed glasses or having the correct prescription.	0
Impaired functional mobility May include patients who need help with IADLS or ADLS or have gait or transfer problems, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices.	1
Environmental hazards May include, but not limited to, poor illumination, equipment tubing, inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered, or outdoor entry and exits.	0
Poly Pharmacy (4 or more prescriptions - any type) All PRESCRIPTIONS including prescriptions for OTC meds. Drugs highly associated with fall risk include but not limited to, sedatives, anti-depressants, tranquilizers, narcotics, antihypertensives, cardiac meds, corticosteroids, anti-anxiety drugs, anticholinergic drugs, and hypoglycemic drugs.	0
Pain affecting level of function Pain often affects an individual's desire or ability to move or pain can be a factor in depression or compliance with safety recommendations.	0
Cognitive impairment Could include patients with dementia, Alzheimer's or stroke patients or patients who are confused, use poor judgment, have decreased comprehension, impulsivity, memory deficits. Consider patients ability to adhere to the plan of care.	1
A score of 4 or more is considered at risk for falling **Total**	**3**

De Jong Gierveld 6-item scale

Question	Description	Answer	Score
1	I experience a general sense of emptiness	More Or Less	1
2	There are plenty of people I can rely on when I have problems	No	0
3	There are many people I can trust completely	No	0
4	There are enough people I feel close to	No	0
5	I miss having people around	No	0
6	I often feel rejected	No	0
		Total	**1**