EXAM INFORMATION

Exam Information Notes **Date of exam** 6/27/2024 **Place of exam** ☑ Virtual in member's home ☐ Virtual outside of member's home

Are you performing the evaluation with audio and video? ☑ Yes, using Doximity as required ☐ No, plan allows telephonic virtual visit

EXAMINER

Examiner name Mannan Burhan Prod **Examiner degree** ☑ MD ☐ DO ☐ NP ☐ PA ☐ MA **Examiner NPI** 4477338899

PERSONAL DETAILS

Member Address

Street Address	Zip Code	City	State
37279 Samantha Cliffs	75052	Grand Prairie	TX

Member Information Notes **Member first name** Firstname9740 **Member last name** Lastname9740 **Date of birth** 1/30/1941 **Age** 83 **Gender** F

Race ☐ American Indian / Alaska Native ☐ Native Hawaiian or other Pacific Islander ☐ Asian ☐ Black / African American ☐ Other / Multiracial ☐ White

Ethnicity

☐ American ☐ Arab ☐ African ☐ Asian ☐ Hispanic / Latino ☐ Chinese ☐ European ☐ Japanese ☐ Other

Preferred language ☐ English ☐ Spanish ☐ Cantonese ☐ Mandarin ☐ Russian ☐ Other

Marital status ☐ Married ☐ Long-term partner ☐ Widowed ☐ Divorced ☐ Single

Current work status ☐ Employed ☐ Unemployed and seeking work ☐ Unemployed and not seeking work (e.g., retired, disabled, unpaid primary care giver) ☐ N/A

Primary email address Firstname9740_Lastname9740_XVBUGLZY@sharklasers.com **Member's Plan** CHDemo-TX

PHYSICIAN OF RECORD (PCP)

PCP Information Notes **Do you receive care from the VA (Veterans Administration)?** ☐ Yes ☐ No **In what city do you receive VA care?**

PCP name Drake Ramoray

PCP Address

PCP Address	Address Line 2	PCP City	PCP State	PCP Zip
1468 Madison Ave	Neurosurgery Department	New York	NY	10029

PCP phone number 8885550000 **PCP fax number** 8885551111 **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

Date	Unknown / Uncertain
	☑ Unknown / Uncertain

Are any of the listed Clinicians the member's PCP?

PCP First Name	PCP Last Name	PCP NPI	PCP Street Address 1	PCP Street Address 2
JOHN	ABRAHAM S	1184707887	5030 CRENSHAW ROAD	SUITE 120

PCP City	PCP State	PCP Zip
PASADENA	TX	77505

CLINICIANS (PHYSICIANS, NURSES, ETC.)

Clinicians & DME Suppliers Notes **Clinicians**

DIAGNOSIS HISTORY

Diagnosis History Notes

DIAGNOSIS HISTORY

Diagnosis	Last Claim Date	Last Signify Date
Arthritis	06/2023	06/2023
Crohn's disease	06/2023	06/2023

MEDICATION REVIEW

Medication Review Notes **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

PRESCRIPTION MEDICATION REVIEW

Medications

Drug Name metFORMIN HCL	**Strength** 500 mg	**Dose** 1 tablet	**Frequency** As needed, daily	**Route** ORAL
Prescriber	**Chosen Diagnoses** Diabetes mellitus	**Entered Diagnoses**	☑ Added By User	☐ Still In Use
O D S Member Medication Id	**N D C** 23155010209			

Drug Name AUVELITY	**Strength** 45-105 mg-mg	**Dose** 1 tablet, extended release	**Frequency** As needed, before bed	**Route** ORAL
Prescriber	**Chosen Diagnoses**	**Entered Diagnoses** Depression	☑ Added By User	☐ Still In Use
O D S Member Medication Id	**N D C** 81968004530			

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

NON-PRESCRIPTION MEDICATION, SUPPLEMENTS AND VITAMINS & HERBALS

OTC & Supplements Notes **Supplements**

ARE ANY OF THE FOLLOWING USED REGULARLY?

☐ Acetaminophen (Tylenol) ☐ Antacid/PPI ☐ Antihistamine ☐ Aspirin, chronic use ☐ Aspirin, intermittent use ☐ Calcium supplements
☐ Coenzyme Q10 (CoQ10) ☐ Fish oil ☐ Ibuprofen (Advil) ☐ Iron ☐ Magnesium ☐ Melatonin ☐ Multivitamin ☐ Naproxen (Aleve)
☐ Probiotic ☐ Stool Softener ☐ Vitamin B12 ☐ Vitamin B Complex ☐ Vitamin C ☐ Vitamin D ☐ Zinc

Reason(s) for OTC or Supplement use?

☐ Pain ☐ Preventive ☐ Osteoarthritis ☐ GERD ☐ Allergic Rhinitis ☐ Constipation ☐ Other

ALLERGY HISTORY

Allergy Review Notes **Allergy Review** ☐ Not obtainable ☐ NKA ☐ Positive history **Reason allergy history not obtainable**

ALLERGIC REACTION (MARK ONLY MOST SERIOUS)

Drug

ACEi/ARB	Cephalosporin	NSAID/aspirin	Penicillin	Radiographic dye
☐ Rash/urticaria	☐ Rash/urticaria	☐ Rash/urticaria	☐ Rash/urticaria	☐ Rash/urticaria
☐ Angioedema	☐ Angioedema	☐ Angioedema	☐ Angioedema	☐ Angioedema
☐ Wheezing	☐ Wheezing	☐ Wheezing	☐ Wheezing	☐ Wheezing
☐ Anaphylaxis	☐ Anaphylaxis	☐ Anaphylaxis	☐ Anaphylaxis	☐ Anaphylaxis

Sulfonamide	Tetracycline	Vaccine
☐ Rash/urticaria	☐ Rash/urticaria	☐ Rash/urticaria
☐ Angioedema	☐ Angioedema	☐ Angioedema
☐ Wheezing	☐ Wheezing	☐ Wheezing
☐ Anaphylaxis	☐ Anaphylaxis	☐ Anaphylaxis

Food

Eggs	Milk	Peanuts	Seafood
☐ Rash/urticaria	☐ Rash/urticaria	☐ Rash/urticaria	☐ Rash/urticaria
☐ Angioedema	☐ Angioedema	☐ Angioedema	☐ Angioedema
☐ Wheezing	☐ Wheezing	☐ Wheezing	☐ Wheezing
☐ Anaphylaxis	☐ Anaphylaxis	☐ Anaphylaxis	☐ Anaphylaxis

Other

Insects/spiders	Latex	Other
☐ Rash/urticaria	☐ Rash/urticaria	☐ Rash/urticaria
☐ Angioedema	☐ Angioedema	☐ Angioedema
☐ Wheezing	☐ Wheezing	☐ Wheezing
☐ Anaphylaxis	☐ Anaphylaxis	☐ Anaphylaxis

Specify other (significant) allergen

LABS & PROCEDURES

Labs & Procedures Notes **Labs and Procedures** ☑ I have reviewed all labs and procedures reported in this section

FROM VALIDATED REPORT(S)

Member has had A1c checked in the last 12 months ☐ Yes ☐ No ☐ Unknown **Recent A1c results (%)**

Result

Based on eGFR values, member has Chronic Kidney Disease ☐ Yes ☐ No

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: 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

RECOMMENDATIONS

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

FAMILY HISTORY

Family History & Health Assessment Notes **Relevant positive family history (in parents, siblings, or children)** ☐ Yes ☑ No ☐ N/A

Alcoholism ☐ Positive Family History **Breast cancer** ☐ Positive Family History **Other cancer** ☐ Positive Family History **COPD** ☐ Positive Family History

Diabetes ☐ Positive Family History **Hypertension** ☐ Positive Family History **Ischemic heart disease** ☐ Positive Family History

Psychiatric disorder ☐ Positive Family History **Stroke** ☐ Positive Family History **Other family history** ☐ Positive Family History **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
☐ 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

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

Has lack of transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

☐ Yes it has kept me from non-medical meetings, appointments, work or from getting things that I need

☐ Yes it has kept me from medical appointments or from getting my medication ☑ No ☐ I choose not to answer ☐ Unknown

Do you have any special needs? ☐ Yes ☑ No

Specify special need(s)

☐ Difficulty seeing ☐ Difficulty reading ☐ Difficulty hearing ☐ Interpreter needed ☐ Other

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

FRAILTY

Level of physical activity ☐ High ☐ Moderate ☐ Low **Do you feel tired or exhausted most of the time?** ☐ Yes ☐ No

Unintentional weight change in the last year ☐ < 10 pounds ☐ >= 10 pounds

ASSESSMENT

☐ Dx: Frailty

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

What is the date of your last flu vaccine?

Member has not received flu shot
☐ Member has not received flu shot

Member declines to answer
☐ 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
☐ Unknown / Uncertain

Have you ever received a vaccine for shingles (Herpes Zoster)? ☐ Yes ☐ No ☐ N/A

When did you get it (best estimation)?

Unknown / Uncertain
☐ Unknown / Uncertain

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
☐ Unknown / Uncertain

COLORECTAL CANCER SCREENING

Date of total colectomy

Unknown / Uncertain
☐ Unknown / Uncertain

Location of last colorectal cancer screening

Method of colorectal cancer screening ☐ Colonoscopy ☐ Sigmoidoscopy ☐ CT Colonography ☐ FOBT/FIT ☐ FIT-DNA ☐ Unknown/uncertain

Date of last colorectal cancer screening

Unknown / Uncertain
☐ Unknown / Uncertain

OSTEOPOROSIS SCREENING/TREATMENT

(For members aged 67 - 85): Have you broken a bone (long bone, spine, or hip) in the last 10 years? ☐ Yes ☐ No ☐ N/A

Did you have a bone mineral test for osteoporosis done in the 2 years prior to the broken bone? ☐ Yes ☐ No ☐ N/A

Did you start treatment for osteoporosis in the 12 months prior to the broken bone? ☐ Yes ☐ No ☐ N/A

Did you have a bone mineral test or start treatment for osteoporosis in the 6 months after you broke a bone? ☐ Yes ☐ No ☐ N/A

Date of last bone mineral density test for osteoporosis

BREAST CANCER SCREENING

Have you had a screening mammogram for breast cancer within the last 2 years? ☐ Yes ☐ No ☐ N/A ☐ Member has had bilateral mastectomy

Date of last mammogram

Unknown / Uncertain
☐ Unknown / Uncertain

Location of last mammogram

RECOMMENDATIONS

☐ H7: Consider influenza vaccination annually ☐ H8: Consider appropriate pneumococcal immunization ☐ H18: Consider breast cancer screening (e.g. mammogram)
☐ H19: Consider colorectal cancer screening ☐ H3: Consider baseline or repeat evaluation for osteoporosis or medical therapy
☐ H35: Consider Herpes zoster (shingles) vaccine

GENERAL

General & Pain Notes **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

In discussing advanced care directives, which of the following do you have in place?

☐ Living will ☐ Medical power of attorney ☐ DNR ☐ Unknown ☑ None

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
☐ 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
☐ Refused

Pain duration ☐ <1 month ☐ 1-6 months ☐ >6 months

Type of pain

☐ Dull ☐ Sharp ☐ Constant ☐ Intermittent ☐ Electric/Shooting (neuropathic) ☐ Visceral

Site(s) of predominant pain

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

HEENT & Pulmonary - Review Notes **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 **Have you had exposure to secondhand tobacco smoke?** ☐ Yes ☐ No

Do you cough nearly every morning? ☐ Yes ☐ No **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

Do you get short of breath with mild exertion? ☐ Yes ☐ No **Have you had a spirometry test in the last 12 months?** ☐ Yes ☐ No ☐ N/A

Date of last spirometry

Unknown ☐ 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 **Have you been exposed to someone with COVID-19?** ☐ Yes ☑ No ☐ Unknown

Have you been tested for the SARS CoV-2 (COVID-19) virus? ☐ Yes ☑ No ☐ Unknown

SARS CoV-2 (COVID-19) test results ☐ Positive ☐ Negative ☐ Pending ☐ Inconclusive ☐ Invalid

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?**

If you have quit smoking, at what age did you quit? **Total years smoking?** **Total pack-years smoking?**

ASSESSMENT

☐ Dx: Night blindness ☐ Dx: Visual loss ☐ Dx: Edentulism, partial ☐ Dx: Edentulism, complete ☐ Dx: Asthma, unspecified ☐ Dx: Emphysema
☐ Dx: Chronic bronchitis ☐ Dx: COPD ☐ Dx: Chronic obstructive asthma ☐ Dx: Vocal cord dysfunction ☐ 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)
☐ P2: Consider further evaluation of pulmonary signs and symptoms ☐ C1: Consider oxygen therapy ☐ H59: Consider hearing evaluation

CARDIOVASCULAR

Cardiovascular Notes **Do you experience shortness of breath at night and/or when lying down (PND)?** ☐ Yes ☐ No

When you exercise or do a physical activity, do you get too winded to continue? (exercise intolerance) ☐ Yes ☐ No

Have you ever had a heart attack (myocardial infarction)? ☐ Yes ☐ No

When was your last heart attack?

Unknown / Uncertain
☐ Unknown / Uncertain

Have you had a coronary artery bypass (CABG) and/or stent placed? ☐ Yes ☐ No

Member has heart failure (systolic, diastolic, unspecified) ☐ Yes ☑ No ☐ Unknown **Member has peripheral vascular (arterial) stent** ☐ Yes ☐ No

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 a pacemaker? ☐ Yes ☐ No **Do you have an implanted defibrillator?** ☐ Yes ☐ No

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 ☐ History of stroke/TIA/thromboembolism ☐ Vascular disease

CHADS2/VASc Score **Have you experienced pain, discomfort, or pressure/heaviness in your chest?** ☐ Yes ☐ No

ANGINA SCREEN - ANSWERS REFLECT UNTREATED SYMPTOMS

Do you get pain or discomfort when you walk uphill or hurry? ☐ Yes ☐ No

When you get any pain or discomfort in your chest, do you slow down or stop? ☐ Yes ☐ No **Does it go away when you stand still?** ☐ Yes ☐ No

Does it go away in < 10 minutes? ☐ Yes ☐ No **Is the pain located in or near the left upper arm, left anterior chest, or sternum?** ☐ Yes ☐ No

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: Heart failure (CHF)

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

GASTROINTESTINAL

GI/GU Notes **Do you experience excessive bloating after eating?** ☐ Yes ☐ No **Member has chronic hepatitis (not acute)** ☐ 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? ☐ Yes ☐ No

GASTROINTESTINAL ASSESSMENT

☐ Dx: Ulcerative colitis ☑ Dx: Regional enteritis (Crohn's) ☐ Dx: Chronic pancreatitis ☐ Dx: GERD ☐ Dx: Chronic hepatitis ☐ Dx: Constipation

GENITOURINARY

In the past 6 months, have you accidentally leaked urine? ☐ Yes ☐ No

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: Personal history of UTIs ☐ Dx: Urinary incontinence

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 ☐ H53: Consider evaluation of history of recent blood in stool
☐ H57: Consider evaluation of history of chronic hepatitis

NEUROPSYCHIATRIC

Neuropsychiatric Notes **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 ☐ No **Residual stroke problems** ☐ Yes ☐ No

Residual stroke issues

☐ Speech ☐ Swallowing ☐ Paralysis ☐ Cognition ☐ Paresis ☐ Other

Have you ever had a TIA (transient ischemic attack)? ☐ Yes ☐ No **Do you have a seizure disorder?** ☐ Yes ☐ No

Date of last seizure

Unknown / Uncertain
☐ Unknown / Uncertain

Severity ☐ Mild ☐ Moderate ☐ Severe **During the past 12 months, have you fallen more than once or twice?** ☐ Yes ☐ No

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

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 USE SCREENING

Alcohol & Drug Use Notes

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 1 **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 dependence, in remission ☐ Dx: Alcohol abuse ☐ Dx: Substance dependence, in remission
☐ Dx: Substance dependence ☐ 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 **Has the member ever had a depressive episode?** ☐ Yes ☑ No ☐ Unknown

PHQ-4

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 **Feeling down, depressed, or hopeless** ☐ 0 ☑ 1 ☐ 2 ☐ 3

Depression Subscale Score 2

PHQ-9

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 **Total Score** **Depression Severity**

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

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

ASSESSMENT

☐ 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

RECOMMENDATIONS

☐ Refer to PCP/BH Professional for further evaluation

DIABETES

Endocrine Notes **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

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

GLUCOMETER

Labs Review Notes **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

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 ☐ Dx: Hyperglycemia

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 ☐ D1: Consider A1c testing

HEMATOLOGY

Oncology Notes **Member has Sickle Cell or other coagulation defect** ☐ Yes ☐ No

Specify sickle cell or other coagulation defect

☐ Sickle cell ☐ Hemophilia ☐ Factor V deficiency ☐ Factor V Leiden mutation ☐ Other

IMMUNOSUPPRESSION

Member has been diagnosed with a condition other than HIV causing an immunocompromised state ☐ Yes ☑ No ☐ Unknown **Specify condition**

Member is taking a medication/drug that would cause immunosuppression ☐ Yes ☑ 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 ☑ No ☐ Unknown **Specify external factor**

CANCER

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 ☐ Unknown **Add other cancer diagnosis**

ASSESSMENT

☐ Dx: Sickle cell ☐ Dx: Hemophilia ☐ Dx: Factor V deficiency ☐ 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

GENERAL APPEARANCE & STATION

Vitals & Devices Notes

General appearance and station

☑ 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)** **Weight (lbs)** **B M I**

Does the member have any obesity-related comorbid conditions? ☐ Yes ☐ No

NESTLE MINI NUTRITIONAL ASSESSMENT MNA

Has food intake declined over the past 3 months due to loss of appetite, digestive problems, chewing or swallowing difficulties?
☐ Severe decrease in food intake ☐ Moderate decrease in food intake ☑ No decrease in food intake

Weight loss during the last 3 months ☐ Weight loss greater than 3 kg (6.6 lbs) ☑ Does not know ☐ Weight loss between 1 and 3 kg (2.2 and 6.6 lbs) ☐ No weight loss

Mobility ☐ Bed or chair bound ☐ Able to get out of bed / chair but does not go out ☑ Goes out

Has suffered psychological stress or acute disease in the past 3 months? ☐ Yes ☑ No

Neuropsychological problems ☐ Severe dementia or depression ☐ Mild dementia ☑ No psychological problems

Body Mass Index (BMI) OR if BMI not available please use calf circumference (CC) in cm
☐ BMI less than 19 ☐ BMI 19 to less than 21 ☑ BMI 21 to less than 23 ☐ BMI 23 or greater ☐ CC less than 31 ☐ CC 31 or greater
☐ BMI/Calf circumference not available

Screening total 11

GENERAL APPEARANCE & STATION ASSESSMENT

☐ Dx: Underweight ☐ Dx: Overweight ☐ Dx: Obesity ☐ Dx: Morbid obesity

BLOOD PRESSURE (BP)

Blood pressure (sitting)

	Diastolic	**Systolic**

BLOOD PRESSURE ASSESSMENT

☐ Dx: Elevated blood pressure reading ☐ Dx: Hypertensive crisis

ARTIFICIAL OPENINGS AND DEVICES

Are you currently using a prosthetic limb? ☐ Yes ☐ No ☐ N/A **Is there any dissatisfaction with your prosthesis?** ☐ Yes ☐ No

Specify prosthesis dissatisfaction

☐ Ill-fitting ☐ Not working properly ☐ Pain or discomfort ☐ Odor ☐ Makes noise ☐ Other

Devices

☐ Ileostomy ☐ Colostomy ☐ Gastrostomy ☐ Cystostomy ☐ CPAP/BiPAP ☐ Tracheostomy ☐ Other

Hearing Aid(s)

☐ Hearing aid(s) available ☐ Hearing aid(s) in use ☐ Hearing aid(s) not in use

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) ☑ Consider further evaluation and management of nutritional status

INTEGUMENT & MUSCULOSKELETAL

Integument & Musculoskeletal Notes **Chronic pressure ulcer (injury)** ☐ Absent ☐ Present

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: Unspecified

☐ Arm ☐ Ankle ☐ Buttock ☐ Elbow ☐ Foot ☐ Forearm ☐ Hand ☐ Head ☐ Heel ☐ Hip ☐ Lower back ☐ Lower leg ☐ Pelvis ☐ Sacral ☐ Toes
☐ Trunk ☐ Upper back ☐ Upper leg

Amputation ☑ Absent ☐ Present

Amputation site(s)

☐ Arm - left ☐ Arm - right ☐ Forearm - left ☐ Forearm - right ☐ Hand - left ☐ Hand - right ☐ Finger(s) - left ☐ Finger(s) - right ☐ Thumb - left
☐ Thumb - right ☐ AKA - left ☐ AKA - right ☐ BKA - left ☐ BKA - right ☐ Ankle - left ☐ Ankle - right ☐ Foot/midfoot - left ☐ Foot/midfoot - right
☐ Great toe - left ☐ Great toe - right ☐ Other toe(s) - left ☐ Other toe(s) - right

Ulnar deviation of digits ☐ Absent ☐ Present **Member has autoimmune condition** ☐ Yes ☐ No

Specify autoimmune condition

☐ Rheumatoid Arthritis ☐ Polymyalgia rheumatica ☐ Lupus (SLE) ☐ Sacroiliitis ☐ 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: 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

COGNITIVE IMPAIRMENT SCREEN

Cognitive Impairment Screen Notes **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

MINI-COG

Number of words recalled: ☐ 0 ☐ 1 ☐ 2 ☐ 3 **CDT interpretation** ☐ Normal ☐ Abnormal ☐ 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

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 **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

PARESIS/PARALYSIS REVIEW

Paralysis or Paresis, limb ☐ Absent ☐ Present

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

DIAGNOSIS VALIDATION

Diagnosis Validation Notes

CONFIRMED DIAGNOSIS			
Diagnosis	Active Management	Inactive Management	Follow up
Crohn's disease	DME in Use		Routine Follow-up With PCP/Specialist
Arthritis	Palliative Care		No Follow-up Needed

UNCONFIRMED DIAGNOSIS	
Diagnosis	Rationale

CASE MANAGEMENT NON-URGENT

Case Management - Non-urgent Notes **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 **An urgent or emergent clinical problem was found during today's assessment.** [ ] Yes [x] 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 [ ] 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)
- [ ] Acute change in mental status or other new neurologic finding [ ] Unmanaged moderate or severe depression or suicide risk [ ] Suspicion of adult or child abuse

Other urgent or emergent issue **Newly discovered diagnosis (or finding) in need of urgent medical attention, specify**

ASSESSMENT

- [ ] Dx: Peripheral arterial disease (PAD)

SUMMARY

Summary Notes

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 NOTES

Plan Notes **Plan information** [ ] P1: Plan notes were discussed with the member

YOUR MEDICATION PLAN:

Leave Behind Notes

- [ ] 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
- [x] 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
- [ ] 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

OTHER

If other significant discussions, please specify

- [ ] None
- [ ] Comment

SIGNATURE

Status [ ] Mobile transcription [x] 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 [ ] Other [ ] Member does not have adequate technology **Cancellation Reason Notes**

Cancellation Reason, specify

Examiner's Full Signature

By signing below, I attest to each of the following:

1. I verified the identity of the Member using his/her name and date of birth.
2. Prior to performing any clinical evaluation (“Virtual Visit”) I obtained the Member’s consent to the Virtual Visit. In obtaining the Member’s consent, I explained the nature and purpose of the Virtual Visit, permitted the Member to ask questions, and answered the Member’s questions (if any).
3. To the best of my knowledge, the medical record entries contained herein are truthful and complete and accurately represent the Member’s voluntary responses.
4. I conducted this Virtual Visit with the Member listed using interactive audio and / or video telecommunications.
5. I indicated the start and end time of this Virtual Visit utilizing the 'start face to face' and 'end face to face' buttons.
6. I understand that any falsification may subject me to administrative, civil or criminal liability.

Date: 06/27/2024

Mannan Burhan Prod, MD
Digitally signed by Mannan Burhan Prod, MD Date 6/27/2024, 10:50:56 AM