Care1ST HEALTH PLAN

Yes, it is all about you.

Health Risk Assessment Form

General Information:

Member Name: _____ Gender: ☐ M ☐ F Provider Name: _____

HIC#: _____ DOB: _____ Date of Service: _____

IPA/MSO: _____ Member ID: _____

NPI#: _____

Present, Past and Social History:

History of Present Illness:

Marital Status: _____

Alcohol: ☐ Yes ☐ No If yes, document amount:

Smoking: ☐ Yes ☐ No If yes, document amount:

Other Drugs: ☐ Yes ☐ No If yes, document name of drug and amount:

Sexually active: ☐ Yes ☐ No

Support System:

Are you living: ☐ **Alone** ☐ **With Someone** **If so, specify: _____**

Do you have a caretaker? ☐ Yes ☐ No

Is the caretaker present during the visit? ☐ Yes ☐ No

I. Evaluation and Management of Cognitive Impairments:

General Observations

Is the patient **alert to person, place, and time**? ☐ Yes ☐ No

Has the patient suffered with significant memory loss? ☐ Yes ☐ No

Immediate recall functioning: ☐ **Good** ☐ **Poor**

Delayed recall functioning: ☐ **Good** ☐ **Poor**

Does the patient suffer from confusion? ☐ Yes - Sometimes ☐ Yes – Most of the time ☐ No

Is the patient ☐ **cooperative or** ☐ **combative** towards your visit? ☐ Yes ☐ No

Is the patient ☐ **drowsy or** ☐ **withdrawn** during the visit? ☐ Yes ☐ No

Family History:

Utilization History:

Emergency Room visits in the last 12 months**?** ☐ Yes ☐ No
Estimated date and Reasons:

Inpatients Admission in the last 12 months? ☐ Yes ☐ No
Estimated date and Reasons:

SNF/LTC/Rehab Admissions in last 12 months? ☐ Yes ☐ No
Estimated date and Reasons:

Past surgical History? ☐ Yes ☐ No
Estimated date and Reasons:

Access to Care:

Have you seen your PCP in the last 12 months? ☐ Yes ☐ No

If yes, were you satisfied with the care you received from your PCP? ☐ Yes ☐ No

If no, what was the reason for not seeing your PCP?

In the last 12 months, were you able to get the care you needed when you felt you needed it? ☐ Yes ☐ No

Nutritional Assessment and Improving Physical Activity:

Weight: _____ Height: _____ **Calculated BMI: _____** Morbid Obesity (BMI >40): _____ Serum Albumin: _____

Do you exercise on a regular basis? ☐ Yes ☐ No If yes, _____ times a week for _____ mins.
Describe the type of exercise?_____
If the patient does not exercise, then:
Do you understand how regular exercise can benefit you? ☐ Yes ☐ No
Have any of your physicians spoken to you about the benefits of exercising regularly? ☐ Yes ☐ No

If weight loss of ≥10% in 6 mos. or ≥5% in 3 mos. or ≥2% in 1 mo, considered clinically significant for malnutrition: _ mild protein-calorie malnutrition 263.1 _ moderate protein-calorie malnutrition 263.0
Dietary counseling for weight loss/gain or any nutritional issues? _ Yes _ No

Management plan: _____

_____

Patient Name:_____ DOB:_____ HIC #_____
Last, First MI

Current Medications :

Drug Allergies/Sensitivities: ☐ Yes ☐ No known allergies
List Allergies:

Medication	Dose	Last Refill Date	Associated Dx

Medication Review	Status	Comments/Clinical Recommendations
Reviewed and documented list of current medications and dosage	☐ Yes ☐ No ☐ Change ☐ No change	

Advance Directive Education/Documentation:

1. Does the patient have an advance directive? ☐ Yes ☐ No
2. If yes, get a copy of it or document name of Provider that has AD: _____

Patient educated on what an AD is and its importance and how they can complete one. ☐ Yes ☐ No

Pain Assessment:

1. Is the pain ☐ Acute ☐ Chronic ☐ Chronic with acute exacerbations?
2. Where is the site of the pain?
3. Describe the pain: Is it sharp, dull, aching, burning, crushing, etc?
4. On a scale of 1 (mild) to 5 (severe) rate the intensity of the pain?
5. Is the patient on any pain management plan? ☐ Yes ☐ No
6. Is the medication an opioid pain medication? ☐ Yes ☐ No

If yes to 6 – ask the following questions:

7. Is the patient responding to the pain management plan? ☐ Yes ☐ No
8. If the patient is on prolonged pain management medications (>4 weeks) assess the following:
   a. Is the patient tolerant to pain medications? ☐ Yes ☐ No
   b. Has the patient increased usage over time? ☐ Yes ☐ No
   c. Have they tried to reduce their dosage or stop taking medications? ☐ Yes ☐ No
   d. Are they continuing to take medications even after the doctor has discontinued it? ☐ Yes ☐ No
   e. Do they have any withdrawal symptoms when they stop medications? ☐ Yes ☐ No
   f. Is there any physiological or psychological dependence to the drug? ☐ Yes ☐ No
9. Opioid Dependence: ☐ Yes ☐ No

Recommendations and Management:

Plan_____

_____

Assessment of Bladder Control:

Does the patient have any issue with bladder control? ☐ Yes ☐ No

Does the patient understand how to improve urinary control? ☐ Yes ☐ No

Review the following with the patient during the visit:

- Dietary habits and fluid intake (e.g. Alcohol and caffeine use)
- Keeping scheduled appointments with the specialists and PCPs
- Developing or adhering to their urinary retention program
- Adhering to prescribed medications and other treatment(s)
- Other tips include having easy access to toilet facilities (bedside toilet, urinal, or bedpan readily available)

Patient Name:_____ DOB:_____ HIC #_____
Last, First MI

Assessment of Activities of Daily Living

Activity	Need No Help (2 pts. each)	Need Some Help (1 pt. each)	Unable to Do At All (0 pts. each)
1. Using the Telephone			
2. Getting to Places Beyond Walking Distance			
3. Grocery Shopping			
4. Preparing Meals			
5. Doing Housework or Handyman Work			
6. Doing Laundry			
7. Taking Medications			
8. Managing Money			
Total Score: ___ =	(___ x 2 =) ___ +	(___ x 1=) ___ +	0

Comments:

Fall Risk Assessment:

Does the patient have a history of fall in the last 12 months? ☐ Yes ☐ No

If yes, was the patient injured as a result of the fall? ☐ Yes ☐ No

Education given to patient on preventing falls? ☐ Yes ☐ No

Assessing and Improving Mental Health:

Have you been diagnosed with depression or any other mental health conditions? ☐ Yes ☐ No

If yes, are you on treatment? ☐ Yes ☐ No

Do you understand how you can improve your mental health? ☐ Yes ☐ No

Review the following simple tips with the patient during the visit:

- Have fun in the things you do during the week.
- Make time for yourself and things you are interested in doing
- Exercise on a regular basis
- Let yourself cry when you need to
- Sleep well
- Eat and drink sensibly
- Maintain relationships/friendships and socialize with them
- Don’t work too hard
- Don’t be scared to seek help from a professional when you need it

Patient Name:_____ DOB:_____ HIC #_____
Last, First MI

Depression Screening Tool PHQ – 9 :

In the past 2 weeks, how often have you been bothered by:

Question (Answer Key: Not at all=0; several days=1; More than half the days=2; nearly every day=3)	Score
Little interest or pleasure in doing things?	
Feeling down, depressed or hopeless?	
Total Score	

Over the last two weeks how often have you been bothered by any of the following:	Not at all (=0)	Several days (=1)	More than half the days (=2)	Nearly everyday (=3)
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or over eating				
Feeling bad about yourself or that you are a failure or have let yourself or your family down				
Trouble concentrating on things such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you been moving a lot more than usual.				
Thoughts that you are better off dead, or hurting yourself in some way				
Total				

PHQ-9 Score: 10; may indicate major depression; Dx code: _____
(296.20 major depression unspecified, single episode, 296.21 mild major depression, single episode, 296.22 moderate major depression, single episode, 296.23 severe major depression, single episode. Use 296.3X for recurrent episodes)

If you have checked off any problems, 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**

Patient Name:_____ DOB:_____ HIC #_____
Last, First MI

Comprehensive Physical Exam:

Does the patient appear in distress? ☐ Yes ☐ No Describe:

Vitals: BP ____/____mmHg Repeated BP ____/____mmHg (Repeat after 15 minutes if Syst > 140 and/or Dias is > 90)

Pulse: /min Resp: /min Temp:

System	Examination Findings	Normal
HEENT	(Examine hearing, ear canal, lymph nodes in neck, septal deviation, etc)	☐ Yes ☐ No
Vision	(Assess visual changes, movement of ocular muscles, etc)	☐ Yes ☐ No
Cardiovascular System	(Look for Heart sounds, murmurs, pacemakers, etc)	☐ Yes ☐ No
Respiratory System	(Evaluate breath sounds, presence/absence of ronchi and crepts, tracheostomy, etc)	☐ Yes ☐ No
Abdomen/Pelvis	(Evaluate for any swellings, guarding, tenderness, enlarged liver/spleen, lymph nodes, etc)	☐ Yes ☐ No
Breast (female only)	(Evaluate for any swellings, tenderness, lymph nodes, etc)	☐ Yes ☐ No
Musculo-skeletal	(Evaluate for any pain, swellings, joint tenderness, range of movement, etc)	☐ Yes ☐ No
Neurological	(Evaluate gait, speech, muscle strength, reflexes, , etc. Review attachment 3 for detailed CNS exam)	☐ Yes ☐ No
Skin	(Evaluate for ulcers, pigmentation, swellings, etc)	☐ Yes ☐ No
Sensory exam	(Evaluate for position/temperature senses, fine touch, decreased senses in extremities, etc)	☐ Yes ☐ No
Other Findings:		

Patient Name:_____ DOB:_____ HIC #_____
Last, First MI

Health Maintenance Assessment:

Preventive Care	Completed	Date of Service
Pneumonia Vaccine	☐ Yes ☐ No ☐ Unk	
Flu Vaccine	☐ Yes ☐ No ☐ Unk	
A1c Testing	☐ Yes ☐ No ☐ Unk	
GRF, estimated (serum creatinine) result: _____ Coding Chronic Kidney Disease Stages: _Stage 4 (585.4): 2 eGFR 15-29 at least 3mos apart; _Stage 5/Renal failure (585.5): eGFR <15 / dialysis _Stage 6/ESRD (585.6): _V45.11 Dialysis Status Is patient on dialysis?☐ Yes ☐ No ☐ Unk	☐ Yes ☐ No ☐ Unk	
Retinal Exam _ non-proliferative retinopathy (362.01) _ proliferative retinopathy (362.02) _ vitreous hemorrhage (379.23)	☐ Yes ☐ No ☐ Unk	
Glaucoma Testing	Yes ☐ No ☐ Unk	
Any fractures in the last 12 months? If yes, have you been dx with Osteoporosis? If yes, is the patient on treatment?	☐ Yes ☐ No ☐ Unk ☐ Yes ☐ No ☐ Unk ☐ Yes ☐ No ☐ Unk	
Colon Cancer Screening - If yes, indicate type of screening test: ☐ FBOT ☐ Sigmoidoscopy ☐ Colonoscopy Provider Name:	☐ Yes ☐ No ☐ Unk	
Mammogram Screening - If yes: Provider Name:	☐ Yes ☐ No ☐ Unk	
History of Mastectomy - If yes: Note ☐ Right ☐ Left ☐ Bilateral Provider Name:	☐ Yes ☐ No ☐ Unk	

(Please see three year HCC diagnosis history form)

Diagnosis	Assessment of Current Conditions (N= New E Existing S= Stable I = Improving W = Worsening)	
	Assessment: ☐ **N** ☐ **E** ☐ **S** ☐ **I** ☐ W **Onset Date:**	**Findings/Plan:**
	Assessment: ☐ **N** ☐ **E** ☐ **S** ☐ **I** ☐ W **Onset Date:**	**Findings/Plan:**
	Assessment: ☐ **N** ☐ **E** ☐ **S** ☐ **I** ☐ W **Onset Date:**	**Findings/Plan:**

Patient Name:____ DOB:__________________ HIC #______________________
Last, First MI

Diagnosis	Assessment of Current Conditions (N= New E Existing S= Stable I = Improving W = Worsening)	
	Assessment: ☐ **N** ☐ **E** ☐ **S** ☐ **I** ☐ W **Onset Date:**	**Findings/Plan:**
	Assessment: ☐ **N** ☐ **E** ☐ **S** ☐ **I** ☐ W **Onset Date:**	**Findings/Plan:**
	Assessment: ☐ **N** ☐ **E** ☐ **S** ☐ **I** ☐ W **Onset Date:**	**Findings/Plan:**
	Assessment: ☐ **N** ☐ **E** ☐ **S** ☐ **I** ☐ W **Onset Date:**	**Findings/Plan:**
	Assessment: ☐ **N** ☐ **E** ☐ **S** ☐ **I** ☐ W **Onset Date:**	**Findings/Plan:**
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	Assessment: ☐ **N** ☐ **E** ☐ **S** ☐ **I** ☐ W **Onset Date:**	**Findings/Plan:**
	Assessment: ☐ **N** ☐ **E** ☐ **S** ☐ **I** ☐ **W** **Onset Date:**	**Findings/Plan:**
	Assessment: ☐ **N** ☐ **E** ☐ **S** ☐ **I** ☐ **W** **Onset Date:**	**Findings/Plan:**

Patient Name:_____ **DOB:**_____ **HIC #**_____
Last, First MI

Did you get any lab work done in the last 6 – 12 months? ☐ Yes ☐ No

If yes, how quickly did you get the results from your lab?

Did the PCP review the lab results with you within 2 weeks of getting the results? ☐ Yes ☐ No

Management and Follow up Care Plan

General Advice and Counseling to Promote Wellness (E.g. advice on Smoking, Alcohol, Drug use, HIV and sexual activity, Diet and Exercise, Immunizations, use of urgent care centers versus emergency rooms, follow up with PCP after discharge from hospitals, etc):

Management Plan for Specific Conditions:

Diagnosis	Management Plan

PRINT PROVIDER NAME/CRENDENTIALS: _____

Provider Signature and Credentials: _____ **Date:**_____

By signing, I represent and acknowledge that both physical examination and clinical condition assessment sections of the Medicare Annual Health Assessment form have been thoroughly completed and the information included in this form, including any diagnosis outlined here, this form is truthful and accurate to the best of my knowledge and understanding based upon a face to face medical evaluation performed on this patient as well as other information that I consider relevant in the exercise of my professional judgment. Care1st reserves the right to validate and code the diagnosis describe by the physician in the Medicare Annual Health Assessment form.