Plan Name: _____

Name: _____

Plan ID #: _____

HIC#: _____

E&M Code: _____

Primary ICD9 Code: _____

Additional Codes (up to 3): _____

Home Visit Initial Patient Assessment

Patient Contact Information

Resident Information		Medical Information	
Date of Birth		Primary Care Physician	
Emergency Contact		Contact Info (phone)	
Relationship to Pt		Case Manager	
Phone Number		Contact Info (phone)	
Advance Directives (type and date)	☐ DNR __/__ ☐ DPOA __/__ ☐ HCP__/__ ☐ Hospice__/__ ☐ Pal Care__/__		

Name and Signatures of Physician and Reviewers

Chart Reviewer		RN/NP/PA	Date of Service ___/___/___	**Chart Reviewer**		RN/NP/PA
Provider**		MD/DO NP/PA	___/___/___	**Provider**		MD/DO NP/PA
Co-Signing Provider (if required)		MD/DO	___/___/___	**Co-Signing Provider**		MD/DO
QA Reviewer		MD/DO PA/NP/RN	___/___/___	**QA Reviewer**		MD/DO PA/NP/RN
Coder		CPC	___/___/___	**Coder**		CPC

**** Person who completes the assessment**

Nurse Practitioner/Physician Initials _____

Matrix Medical Network Health Risk Assessment

Reason For Home Visit:
History of Present Illness (including chief complaint and recent hospital course, if applicable)
CC:

Active and Inactive Medical Diagnoses that Impact this Patient's Care:

Medical History Diagnosis	Active (A) Inactive (I) or Chronic (C) A	I	C	Past Surgical History (Include Date)
1.	☐	☐	☐	
2.	☐	☐	☐	
3.	☐	☐	☐	
4.	☐	☐	☐	
5.	☐	☐	☐	
6.	☐	☐	☐	
7.	☐	☐	☐	
8.	☐	☐	☐	
9.	☐	☐	☐	
10.	☐	☐	☐	
11.	☐	☐	☐	
12.	☐	☐	☐	Hospitalizations/Nursing Home Admissions
13.	☐	☐	☐	Original NH Admit Date:
14.	☐	☐	☐	Current NH Admit Date:
15.	☐	☐	☐	Most Recent Hospital Dates:
16.	☐	☐	☐	
17.	☐	☐	☐	
18.	☐	☐	☐	
19.	☐	☐	☐	
20.	☐	☐	☐	
☐ Additional information on Addendum (Page 14)				

Nurse Practitioner/Physician Initials _____

Drug Allergies and Sensitivities:	☐ No Known Medication Allergies	

Current Medications
(Prescription and Over the Counter Medicine)

#	Drug (Include Dose, Route and Frequency)	Associated Diagnosis
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
	Additional Information on Addendum ☐	

Nurse Practitioner/Physician Initials _____

Health Maintenance

Last PE: _____/ _____ Stools, occult blood test: _____/_____ Colonoscopy/Sigmoidoscopy: _____/_____

Dental Exam: _____/_____ Eye Exam: _____/_____ Foot Exam: _____/____ DXA _____/____

Flu Shot: ____/____ Pneumovax ____/_____ Other _____

WOMEN: Last: PAP smear: ____/_____ Mammogram: ____/____ Breast Exam: ____/_____

MEN: Last: Rectal/Prostate exam: _____/_____ PSA: _____/_____

Surveillance: PPD: date___/____ Results _____ CXR: Date ___/___ Results _____

Personal and Social History

Marital status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er) ☐ Separated
Occupation: _____ Retired: ☐ Yes ☐ No

Education: _____

Alcohol/ Tobacco/ Drugs Risk Screen

Have you ever smoked cigarettes, a pipe or cigars or chewed tobacco? ☐ Yes ☐ No
Are you currently using?_____ ☐ Yes ☐ No
If yes, how much and for how long?_____
Did you ever drink alcohol? ☐ Yes ☐ No
Do you still drink? ☐ Yes ☐ No
If yes, what is your typical use of alcohol?_____
Do you think it is a problem? ☐ Yes ☐ No

Some people have been in relationships where there is abuse or violence, or have had abuse or violence happen to them by strangers or as children or young people.
Has something like this has happened to you now or in the past? ☐ Yes ☐ No
Could you explain a bit more? _____

Have you ever used any street drugs or taken prescription medications that were not prescribed for you or in larger amounts than were prescribed? ☐ Yes ☐ No
If yes, what drugs/meds? _____ For how long?_____

Are you at risk for HIV/AIDs or other sexually transmitted diseases? ☐ Yes ☐ No
Have you been tested? ☐ Yes ☐ No

Patient and Caregiver Support System

Do you live:
☐ Alone ☐ With a spouse ☐ With children ☐ With other relatives
☐ With non-relatives (such as a friend) ☐ With a paid caregiver (such as a nurse or housekeeper)
☐ Other: _____

Who takes care of you when you are ill? _____

How do you get to your health care appointments/access the community?
_____

Nurse Practitioner/Physician Initials _____