Molina Medicare Health Evaluation

FAX COMPLETED FORM TO: 877-682-2216

Member Name: _____ **PCP Name:** _____

Date of Birth: _____ **Age:** _____

HIC#: _____ **DATE OF SERVICE:** _____

REASON FOR VISIT: _____

_____

_____

PAST MEDICAL CONDITIONS *(Diagnoses included here that are still active should also be assessed during this visit and included in the assessment section per CMS guidelines)*

Condition	Condition

CURRENT MEDICATIONS: *Please list current prescription and non-prescription medicines, vitamins, home remedies, herbs. Attach additional page if needed.*

☐Medication reconciliation completed and reviewed with patient (discussed issues/questions)

ALLERGIES OR REACTIONS TO MEDICATIONS: _____

VITAL SIGNS (*required):

BP* _____ Temp _____ Height* _____ Weight* _____ BMI* _____ Pulse Ox _____

REVIEW OF SYSTEMS

System	Negative	Positive
HEENT		Eye pain, ear pain, neck pain, visual problems, masses, hoarseness, other:
Respiratory		Cough, wheezing, sputum production, hemoptysis, other:
Cardiovascular		Chest pain, SOB, palpitation, orthopnea, other:
Gastrointestinal		Abdominal pain, nausea, vomiting, diarrhea, other:
Genitourinary		Difficult or painful urination, nocturia, frequency, hematuria, other:
Musculoskeletal		Joint pain, swelling, other:
Endocrine		Polyuria, heat or cold intolerance, other:
Neurological		Disoriented, Paresthesias, weakness, other:
Skin		Skin breakdown, rashes, pruritis, other:
Psychiatric		Fatigue, hallucinations, anxiety, depressed, other:

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PHYSICAL EXAMINATION

General Appearance	Normal	Abnormal Findings
Skin		
Head		
Eyes		
Ears		
Nose		
Throat		
Neck		
Lungs		
Breast		
Heart		
Abdomen		
Musculoskeletal		
Prostate		
Rectal/GU		
Extremities		
Neurological		

ADVANCED DIRECTIVES: (*Please discuss and verify*)

Patient has an active Advance Directive in place OR you have discussed end-of- life care at this visit.

If done, write in today's date: _____

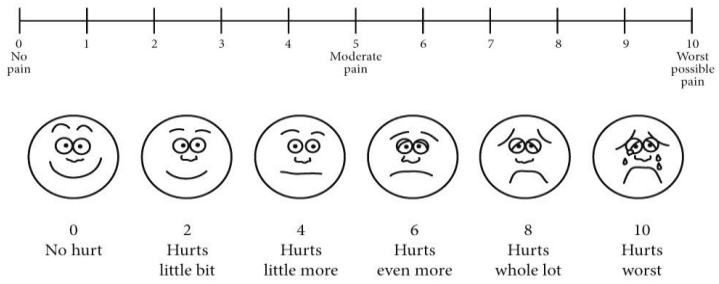
PREVENTIVE HEALTH COUNSELING

Patient counseled on (if relevant): (*please circle Yes or No)*

1. Improving and maintaining physical activity?	Yes	No
2. Bladder control issues and treatment options?	Yes	No
3. Fall risks and fall prevention?	Yes	No
4. Improving and maintaining physical health?	Yes	No
5. Improving and maintaining mental health?	Yes	No

PAIN SCALE: Indicate which below best describes pain level and describe the type of pain and location.

_____



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FUNCTIONAL ASSESSMENT

Activity	Score	Comments
CONTINENCE 0 = incontinent (or catheterized and unable to manage alone) 1 = independent		If 0, has patient been counseled?
MOBILITY/TRANSFERRING 0 = unable, needs help in moving from bed to chair or requires complete transfer, uses wheelchair 1 = moves in and out of bed unassisted (mechanical aids are acceptable)		If 0, has patient been counseled?
FEEDING 0 = needs partial or total help with feeding or requires parenteral feeding 1 = gets food from plate into mouth independently, prep of food may be done by another person		
BATHING 0 = needs help with bathing or getting in and out of the shower 1 = independent (bathes self completely, disabled extremity)		
DRESSING 0 = needs help with dressing self or needs to be completely dressed gets 1 = clothes from closet and puts on clothes complete with fasteners		
TOILET USE 0 = needs help transferring to the toilet, unable to clean self, uses bedpan or commode 1 = goes to toilet, gets on and off, cleans genital area without help		
TOTAL FUNCTIONAL SCORE (0 – 6)		

PREVENTIVE HEALTH REVIEW

1. Colon Cancer Screening
   a. Fecal Occult Blood Test (annual)
      Date performed: ____/____/_____
      Result: _____
      Date Ordered: ____/____/_____
   b. Or sigmoidoscopy (within 4 years)
      Date performed: ____/____/_____
      Date ordered: ____/____/_____
   c. Or Colonoscopy (within 9 years)
      Date performed: ____/____/_____
      Date ordered: ____/____/_____
2. Glaucoma Screening (age >65, annual)
   Date performed: ____/____/_____
   By: _____
   Date referred: ____/____/_____
3. Cardiovascular patients (age 18-75, H/O MI, CABG, PTCA, ischemia)
   LDL-C (annual)
   Date performed: ____/____/_____
   Result: _____
   Date Ordered: ____/____/_____

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PREVENTIVE HEALTH REVIEW (continuation)

4. Diabetic Patients

   a. LDL-C (annual)
      Date performed: ____/____/_____
      Result: _____
      Date Ordered: ____/____/_____

   b. U/A (annual)
      Date performed: ____/____/_____
      Microalbumin Result: _____
      Date Ordered: ____/____/_____

   c. Hba1c (annual)
      Date performed: ____/____/_____
      Result: _____
      Date Ordered: ____/____/_____

   d. Retinal Exam (annual by ophthalmologist/optometrist)
      Date performed: ____/____/_____
      By: _____
      Date referred: ____/____/_____

5. Influenza Vaccine (annual)
   Date given: ____/____/_____

6. Pneumovax received (age >65 or high risk): Yes No *(circle Yes or No)*

ASSESSMENT AND TREATMENT PLAN

Diagnosis (list ALL chronic and acute conditions)	Status/Assessment	Treatment Plan

COMPLETED BY:

_____ _____ *(circle credential)* MD, DO, NP, PA, PA-C other_____ _____

Provider Name **Signature** **Date**