CARE FOR OLDER ADULTS ASSESSMENT FORM

Patient: _____ DOB: _____ Member ID#: _____

FUNCTIONAL STATUS ASSESSMENT

Cognitive Status: Intact Not Oriented: Person, Place, Time ***(circle)***

Ambulation Status: Normal/Good Fair Poor Independent: **Y / N** Non Ambulatory: **Y / N**
Needs assistive device: **Y / N** *Cane Walker Wheel Chair Scooter*

Sensory Ability: Hearing: Good Fair Poor Impaired: *Deaf Use of Hearing Aids/ Device*
Speech: Unimpaired Impaired: Language Barrier Present: **Y / N:** _____
Vision: Good Fair Poor Impaired: *Uses Glasses/contacts Cataracts Glaucoma Macular Degeneration DM Retinopathy Blind*

Activities of Daily Living: Completely Independent: **Y / N (if NO, circle type of assistance required below)**
Assistance with ADLs: Bathing, Dressing, Eating, Transferring, Toileting, Walking, Continence
Assistance with IADLs: Shopping, Driving OR Using Public Transportation, Using the Phone, Meal Preparation, Housework, Home Repair, Laundry, Taking Medications, Handling Finances
Has Caregiver in place: **Y / N N/A**

Functionally Independent: Currently Working: **Y / N** Able to perform a job: **Y / N** Able to Exercise: **Y / N**

Claim Coding: CPT 1170F must be reported on the claim to qualify for Functional Status Assessment.

ADVANCE CARE PLANNING (ACP)

Does the patient have: Advance Directives: **Y / N** Living Will: **Y / N** Surrogate Decision Letter: **Y / N**

Date discussed with Patient/ Family Member: _____/_____/ 2018 ***Copy of ACP Document in Chart: Y / N**
***If Yes, Please attach a copy of the Advance Care Plan to this form**

Claim Coding: HCPCS S0257 or CPT 1157F, 1158F, 99497 must be reported on the claim to qualify for Advance Care Planning.

MEDICATION REVIEW/LIST

Medication Review Completed: Y / N
***Please attach a copy of current medications (i.e. Medication List of office note with provider signature and date reviewed).** *Both Medication review and Medication list must be submitted together for the same date of service.*

Claim Coding: CPT 1159F (Med List) and 1160F or G8427(Med Review)must be reported on the same claim to qualify for Medication List/Review.

COMPREHENSIVE PAIN ASSESSMENT

Has Pain: Y / N (must select option Y or N)

If chronic pain mark Level of Pain
No pain Moderate Pain Worst Pain
I----I----I----I----I----I----I----I----I----I----I
0 1 2 3 4 5 6 7 8 9 10 **Location(s) of Pain_____**

Claim Coding: CPT 1125F (pain present) or 1126F (pain absent) must be reported on the claim to qualify for Pain Screening.

Physician's Name: _____ **Print physician's name (if other)** _____

Physician's Signature: _____ **Date Assessment completed:** _____

Comments: _____