

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	CONSTANCE B HARRIS
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1964-12-04
Evaluation Date :	2021-7-8 08:00 AM
Visit Type :	In Person

Demographics

Plan	VPHP - VIRGINIA PREMIER
Program	MEDICARE
LOB	DSNP
Name	CONSTANCE B HARRIS
Gender	Female
Address	206 HOSPITAL ST
City	RICHMOND
State	VA
Zip	23803-5801
Date of Birth	1964-12-04
Age(as of date)	56
Marital Status	Divorced
Member Identification Number	11000440
HICN	1MG3G94VA03
Phone Number	8047736571
Cell Number	8042890485
Alternate Contact Number	
Email	harrisconstance16@gmail.com
Emergency Contact	Shawishi Washington
Phone Number	804-724-9616
Primary Care Physician	JOSEPH, LERLA G
Phone Number	8042304913
PCP Address	849 S Sycamore St Ste A
PCP City	Petersburg
PCP State	VA

PCP Zip	238035801
PCP County	Richmond City
Office ID	P9058496
Office Name	CHARLES CITY MEDICAL GROUP

1. Race

- | | | |
|---|---|--|
| <input type="checkbox"/> Caucasian | <input checked="" type="checkbox"/> African American | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Latino | <input type="checkbox"/> Native American | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Alaskan Native | <input type="checkbox"/> Other | |

Patient's Ethnicity

- | | | |
|--|---|--|
| <input type="checkbox"/> Hispanic | <input checked="" type="checkbox"/> Non-Hispanic | <input type="checkbox"/> Other Ethnicity |
| <input type="checkbox"/> Prefer not to say | | |

2. Preferred language

- | | |
|--|--------------------------------|
| <input checked="" type="checkbox"/> English | <input type="checkbox"/> Other |
|--|--------------------------------|

Previously Documented Conditions

Covid Screening

In the last 14 days, have you:

Traveled internationally?	Yes	No
Had known exposure to anyone diagnosed with Corona virus (COVID-19)	Yes	No
Had close contact with someone who has traveled to a high risk area?	Yes	No
Developed Fever?	Yes	No
Developed Cough?	Yes	No
Developed Flu like symptoms?	Yes	No
Developed Shortness of breath?	Yes	No

Self-Assessment and Social History

3. How much school have you completed?

- | | | |
|---|--|--|
| <input type="checkbox"/> Less than 3rd grade | <input type="checkbox"/> Completed 3rd grade | <input type="checkbox"/> Completed 8th grade |
| <input type="checkbox"/> Completed 12th grade | <input type="checkbox"/> Attended College | |

comments

Highschool graduate member states "I graduated June 19, 2021 last month"

4. When you get written information at a doctor's office would you say it is

- ☐ Very difficult
- ☐ Somewhat difficult
- ☐ Easy
- ☒ **Very easy to understand**

5. When you read the instructions on a prescription bottle would you say that it is

- ☐ Very difficult
- ☐ Somewhat difficult
- ☐ Easy
- ☒ **Very easy to understand**

6. How confident are you in filling out medical forms by yourself?

- ☐ Not at All Confident
- ☐ Not Very Confident
- ☐ Confident
- ☒ **Very Confident**

7. How would you rate your health compared to other persons your age?

- ☐ Excellent
- ☒ **Good**
- ☐ Fair
- ☐ Poor

8. During past 3 months, has your physical and or emotional health limited your social activities with family, friends, neighbours or groups?

- ☐ Often
- ☐ Sometimes
- ☐ Almost Never
- ☐ Never

comments

No

9. Where do you currently live?

- ☐ Home
- ☒ **Apartment**
- ☐ Assisted Living
- ☐ Nursing Home
- ☐ Homeless
- ☐ Other

comments

apartment setting

10. Do you have someone you can rely on to help if you are sick or have problems you need to discuss?

- ☒ **Yes**
- ☐ No

11. Who do you currently live with?

- ☒ **Alone**
- ☐ Spouse
- ☐ Partner
- ☐ Relative
- ☐ Family
- ☐ Friend
- ☐ Personal Care Worker

 Describe

relies on her son which lives local if she becomes sick; however, she lives alone

12. Are you currently a caregiver for someone?

- ☐ Yes
- ☒ **No**

13. Tobacco use

- ☐ Current
- ☒ **Former**
- ☐ Never

comments

former smoker

 Type

- ☒ **Cigarettes**
- ☐ Cigars
- ☐ Chewing Tobacco

☐ Vaping

☐ Other

☒ How Many

☐ 1 - 3 a day

☐ 1/2 a pack

☒ 1 pack

☐ More than 1 pack

☐ Other

comments

quit Dec 5, 2020

14. Alcohol Use

☐ Current

☐ Former

☒ Never

comments

only social drinker. Maybe drinks 1-3 beers/year

15. Do you or have you used recreational drugs or pain medication?

☒ Yes

☐ No

☒ Which drugs or medication

crack/cocaine former user and quit using drugs in 2003

16. Do you have a Healthcare Proxy?

☐ Yes

☒ No

☐ Don't Know

17. Do you have a Durable Power of Attorney?

☐ Yes

☒ No

☐ Don't Know

18. Do you have an Advance Directive?

☐ Yes

☒ No

☐ Don't Know

Within the past 12 months we worried whether our food would run out before we got money to buy more. Was that _____ for your household?

☐ Often True

☐ Sometimes True

☒ Never True

Within the past 12 months the food we bought just didn't last and we didn't have money to get more. Was that _____ for your household?

☐ Often True

☐ Sometimes True

☒ Never True

Activities of Daily Living

19. Do you have any difficulty with the following activities?

A. Getting in or out of bed	No	Need Some Help	Need Total Help
B. Getting in or out of chairs	No	Need Some Help	Need Total Help
C. Toileting	No	Need Some Help	Need Total Help
D. Bathing	No	Need Some Help	Need Total Help
E. Dressing	No	Need Some Help	Need Total Help
F. Eating	No	Need Some Help	Need Total Help
G. Walking	No	Need Some Help	Need Total Help

H. Going up or down stairs	No	Need Some Help	Need Total Help
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Medical History

20. Do you use any assistive devices? (Check device or none if no devices used)

☐ None

☒ Cane

☐ Wheel Chair

☐ Bed Pan

☐ Walker

☐ Bedside Commode

☒ Other

☐ Prosthesis

☐ Urinal

21. Are you currently seeing any specialists?

☒ Yes

☐ No

Medical Specialty	Specialist	For
Cardiologist	unknown MD	CHF
Nephrologist	Dr. Kudiragic	CKD
Gastroenterologist	Dr. Leggins	GERD
Podiatrist	Dr. Faircloth	T2DM
Ophthalmologist	VA eye institute	diabetic retinopathy

22. In the past 12 months how many times have you?

A. Seen your PCP	None	1	2	3	4	5 or more
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Comment: > 5

B. Visited the Emergency Room	None	1	2	3	4	5 or more
C. Stayed in the hospital overnight	None	1	2	3	4	5 or more
D. Been in a nursing home	None	1	2	3	4	5 or more
E. Had Surgery	None	1	2	3	4	5 or more

23. Have you ever been hospitalized prior to the last 12 months?

☒ Yes

☐ No

[Describe](#)

last hospitalized for CVA in 2020 for 2-3 days

24. In the past year have you received health services from any of the providers below:

Physical Therapist	Yes	No
Occupational Therapist	Yes	No
Dietician	Yes	No
Social Worker	Yes	No

Comment: Unknown (likely no)

Pharmacist	Yes	No
Speech Therapist	Yes	No
Chiropractor	Yes	No
Personal Care Worker (HHA, CNA, PCA)	Yes	No

Comment: HHA comes 5 days a week; hours 10am-3pm

Meals on Wheels	Yes	No
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25. In the past two years have you received any of the treatments below?

Chemotherapy	Yes	No	Unknown
Catheter Care	Yes	No	Unknown
Oxygen	Yes	No	Unknown
Wound Care	Yes	No	Unknown
Regular Injections	Yes	No	Unknown
Tube Feedings	Yes	No	Unknown

Family History

26. Family History

☒ Yes ☐ No

Family Member	Medical Condition	Cause of Death
Father	CHF, MI, CAD, HTN, T2DM	CHF
Sibling1	CHF	CHF

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	No
Breast Exam/Mammography	Yes
Cervical Screening	Yes
Bone Density	No
Prostate Exam/PSA	No
If Diabetic Eye Exam	Yes
If Diabetic Foot Exam	Yes
If Diabetic Hgb A1c screen	Yes
Lipid Panel	Yes

28. Last colonoscopy if more than 2 years ago

☐ 3 – 5 years ago ☐ 6 – 10 years ago ☐ > 10 years ago

☒ Never ☐ Don't know

comments discussed the importance of preventative care with member

29. Screen for abnormal glucose / diabetes - age 40 - 70

☒ Yes ☐ No ☐ NA

30. One time screen for Abdominal Aortic Aneurysm if male with history of smoking, age 65 - 75

☐ Yes ☒ No ☐ NA

31. One time screen for Hepatitis C if born between 1945 - 1965

☒ Yes ☐ No ☐ NA

32. Do you get Flu Vaccine each year?

☒ Yes ☐ No

33. Have you been vaccinated for Pneumonia?

☒ Yes ☐ No ☐ Unknown

↳ Pneumovax

☐ Yes ☐ No

↳ Prevenar

☐ Yes ☐ No ☒ Unknown

34. Have you been vaccinated for Herpes Zoster?

☐ Yes ☒ No

comments discussed preventative care

Allergies / Medications

35. Allergies

☒ Yes ☐ No

Substance	Reaction
pravastatin	myalgias, rash
PCN	rash, swelling, itching

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
gerd	OMEPRAZOL E	CAP 40MG	PO = By Mouth	QD	vango NP	Taking	Not Taking
t2dm	OZEMPIC	INJ 2/1.5ML	PO = By Mouth	QW	vango NP	Taking	Not Taking
htn	AMLODIPINE	TAB 10MG	PO = By Mouth	QD	vango np	Taking	Not Taking
htn	HYDRALAZI NE	TAB 50MG	PO = By Mouth	TID	vango NP	Taking	Not Taking
htn, chf	CARVEDILOL	TAB 25MG	PO = By Mouth	BID	vango NP	Taking	Not Taking

hyperlipidem ia	ATORVASTAT IN	TAB 40MG	PO = By Mouth	HS	vango NP	Taking	Not Taking
peripheral neuropathy	PREGABALI N	CAP 50MG	PO = By Mouth	BID	Dr. Sonta faircloth	Taking	Not Taking
t2dm	LANTUS	INJ 100/ML 25units	SQ = Subcutaneou s	BID	vango NP	Taking	Not Taking
chf	FUROSEMIDE	TAB 20MG	PO = By Mouth	BID	Kunaparaju	Taking	Not Taking
prophylatic	aspirin	81mg	PO = By Mouth	QD	vango np	Taking	Not Taking
IDA	ferrous sulfate	325mg	PO = By Mouth	TID	vango NP	Taking	Not Taking
ADHD	BUPROPN HCL	150mg	PO = By Mouth	QD	sherma francis	Taking	Not Taking
t2dm	humalog	12units	SQ = Subcutaneou s	TID	vango NP	Taking	Not Taking

36. Over the Counter Medications / Supplements

☐ Yes

☒ No

37. Chronic Use of

☐ None

☒ ASA

☐ Steroids

☒ Insulin

☐ Anticoagulants

☒ Statins

☐ Biphosphonate

38. Medication Compliance and Knowledge of Use and Disease

1. Do you ever forget to take your medicine?	Yes	No
Comment: member states "I don't forget, I intentionally decide some days not to take it because the pandemic has me lazy and some days I don't feel like taking my medications." **patient education - discussed the importance of medication compliance		
2. Do you sometimes not pay enough attention to your medication?	Yes	No
Comment: pt education provided		
3. Do you know the longterm benefit of taking your medicine as told to you by the doctor or pharmacist?	Yes	No
4. When you feel better do you sometimes stop taking your medicine?	Yes	No
5. Sometimes if you feel worse when you take your medicine do you stop taking it?	Yes	No
6. Do you sometimes forget to refill your prescription on time?	Yes	No
Comment: needs hydralazine 25mg PO RX now (empty bottle). Member is calling pharmacy today to refill.		

Review of Systems and Diagnoses

Eye Problems (Glaucoma, Cataracts, Macular Degeneration, Blindness, Retinal

Detachment, Other)

☒ Yes

☐ No

Diagnoses

- ☒ Cataracts

☐ Glaucoma

☐ Macular Degeneration

☒ Retinal Disease
- Cataracts

Describe

☒ Active

☐ History

☐ Medications

☐ Biopsy

Supported by

☐ Secondary to Diabetes

☒ Yes
- Difficulty with vision
- Describe

☒ Active

☐ Legally Blind

☐ Yes

Retinal Disease

Describe

☒ Active

☐ History

☐ Medications

☐ Biopsy

Supported by

☐ Secondary to Diabetes

☒ Yes

Vitreous Hemorrhage

☐ Yes

☒ No

☒ Difficulty with vision

☐ Hyperopia

☐ Myopia

☐ Others

History of

☐ Symptoms

☐ Test results

☐ DME

Rule out

☒ Physical Findings

☐ Image studies

☐ Other

Do you wear glasses or contacts?

☒ Yes

☐ No

Do you have trouble seeing even with glasses?

☒ Yes

☐ No

comments

"I have trouble seeing far away"

Do you need help in and out of the house because you can't see well?

☐ Yes

☒ No

Do you have problems seeing at night?

☒ Yes

☐ No

Do you have eye pain?

☐ Yes

☒ No

Do you have problems with tearing?

☐ Yes

☒ No

Do you have a problem with dry eye?

☐ Yes

☒ No

Ear Problems (Hard of hearing, Deaf, Vertigo, Ear Infections)

☐ Yes ☒ No

Nose Problems (Nose Bleeds, Sinus infections, Other)

☐ Yes ☒ No

Mouth and Throat Problems (Difficulty Chewing, Difficulty Swallowing, Bleeding Gums, Other)

☐ Yes ☒ No

Neck Problems (parotid Disease, Carotid Stenosis, Other)

☐ Yes ☒ No

Respiratory Problems (COPD, Emphysema, Asthma, Chronic Bronchitis Pneumonia, Other)

☐ Yes ☒ No

Cardiovascular (Hypertension, Angina, Ischemic Heart Disease(CAD), Myocardial Infarction, Other)

☒ Yes ☐ No

Diagnoses

- | | |
|--|--|
| <input type="checkbox"/> Abnormal Cardiac Rhythm | <input type="checkbox"/> Aneurysm |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> Cardio – Respiratory Failure / Shock | <input type="checkbox"/> Cardiomyopathy |
| <input checked="" type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Deep Vein Thrombosis |
| <input checked="" type="checkbox"/> Hyperlipidemia | <input checked="" type="checkbox"/> Hypertension |
| <input checked="" type="checkbox"/> Ischemic Heart Disease (CAD) | <input type="checkbox"/> Myocardial Infarction |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Pulmonary Hypertension |
| <input type="checkbox"/> Valvular Disease | <input type="checkbox"/> Other |

Congestive Heart Failure

Describe

☒ Active ☐ History of ☐ Rule out

Supported by

<input type="checkbox"/> Ejection fraction	<input type="checkbox"/> Cardiomegaly	<input type="checkbox"/> Orthopnea
<input type="checkbox"/> DOE	<input type="checkbox"/> PND	<input type="checkbox"/> S3
<input checked="" type="checkbox"/> Medications	<input checked="" type="checkbox"/> Peripheral edema	<input type="checkbox"/> Other

Describe

☐ Diastolic ☐ Systolic ☒ Unknown

Secondary to Hypertension

☒ Yes ☐ No

Is patient on an ACE or ARB

☒ Yes ☐ No

Is patient on a Beta Blocker

☒ Yes ☐ No

Hyperlipidemia

Describe

☒ Active ☐ History of ☐ Rule out

Supported by

- ☐ Lab results
- ☒ **Medication**
- ☐ Other
- ☐ Is patient on Statin
 - ☒ **Yes**
 - ☐ No
- Hypertension
 - ☐ Describe
 - ☒ **Active**
 - ☐ History of
 - ☐ Rule out
 - ☐ Supported by
 - ☐ Physical Exam
 - ☒ **Medications**
 - ☐ Symptoms
 - ☐ Other
- ☐ Adequately controlled
 - ☒ **Yes**
 - ☐ No
 - ☐ UnKnown
- Ischemic Heart Disease (CAD)
 - ☐ Describe
 - ☒ **Active**
 - ☐ History of
 - ☐ Rule out
 - ☐ Supported by
 - ☐ Cardiac Cath
 - ☐ History of coronary stent
 - ☐ History of CABG
 - ☒ **ECG**
 - ☒ **Medications**
 - ☐ Other
 - ☐ Diagnosis of angina

comments

member denies prior MI

History of Chest Pain

☐ Yes ☒ **No**

History of Intermittent Claudication

☐ Yes ☒ **No**

Implanted Pacemaker

☐ Yes ☒ **No**

Implanted Defibrillator

☐ Yes ☒ **No**

Do you have abnormal heart beats?

☐ Yes ☒ **No**

Does your heart race?

☐ Yes ☒ **No**

Do you sleep on more then one pillow?

☒ **Yes** ☐ No

have you ever have fluid in your lungs?

☐ Yes ☒ **No**

Do your legs or ankles swell up?

☒ **Yes** ☐ No

Do you follow a special diet?

☒ **Yes** ☐ No

comments

diabetic

Do you have headaches?

☐ Yes ☒ **No**

Do you feel light headed when you stand up?

☐ Yes ☒ **No**

Gastrointestinal Problems (Ulcer, Reflux, Hiatal Hernia, Colitis, Other)

☒ Yes ☐ No

↳ Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Bowel Obstruction | <input type="checkbox"/> Cachexia |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Gastroparesis |
| <input checked="" type="checkbox"/> GERD | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Ulcer Disease | <input type="checkbox"/> Other |

GERD

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☒ Heartburn /
Dyspepsia

☐ Regurgitation

☒ Medications

☐ Other

History of blood in stool

☐ Yes

☒ No

History of black stools

☐ Yes

☒ No

History of Heartburn / Dyspepsia

☒ Yes

☐ No

↳ Describe

☐ Occasionally

☒ Chronic

History of Vomiting or Regurgitation

☐ Yes

☒ No

History of pain after eating

☐ Yes

☒ No

History of Jaundice

☐ Yes

☒ No

Do you follow a special diet?

☒ Yes

☐ No

Do you have frequent abnormal abdominal pain?

☐ Yes

☒ No

Do you have intermittent nausea or vomiting?

☐ Yes

☒ No

Do you have trouble with constipation?

☐ Yes

☒ No

Does diarrhea limit your ability to get out of the room or socially?

☐ Yes

☒ No

Do you see blood in your urine?

☐ Yes

☒ No

Do you have Frequent Stomach Pain

☐ Yes

☒ No

Bowel Movements

☒ Normal

☐ Abnormal

comments

daily BMs

Abdominal Openings

☐ Yes

☒ No

Rectal Problems

☐ Yes

☒ No

Last Bowel Movement

☒ Today

☐ 1-3 days ago

☐ >3 days ago

Neuro / Psych Problems (Stroke, Parkinson's disease, Seizures Paraplegia, Depression, Other)

☒ Yes

☐ No

Diagnoses

- ☐ Alcohol Dependence

☐ Bipolar Disorder

☐ Cerebral Palsy

☐ Dementia

☐ Drug Dependence

☒ Generalized Anxiety Disorder

☐ Hemiparesis

☐ Insomnia

☐ Migraine Headaches

☐ Muscular Dystrophy

☐ Parkinson's disease

☐ Restless leg syndrome

☐ Seizure Disorder

☒ Stroke

☐ TIA

☒ Other
- ☐ Amyotrophic Lateral Sclerosis

☐ Cerebral Hemorrhage

☐ Delusional Disease

☒ Depression

☐ Fibromyalgia

☐ Guillain-Barre Disease

☐ Huntington's Chorea

☐ Intellectual and or Developmental Disability

☐ Multiple Sclerosis

☐ Myasthenia Gravis

☒ Peripheral Neuropathy

☐ Schizophrenia

☐ Spinal Cord Injury

☐ Subdural Hematoma

☐ Traumatic Brain Injury

Depression

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Symptoms

☐ PHQ 2 / 9

☒ Use of antidepressant medication

☐ Other

Major

☐ Yes

☒ NO

Generalized Anxiety Disorder

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

☒ Symptoms

☐ GAD 7

☐ Antianxiety medication

- ☐ Other
- Peripheral Neuropathy**
 - ↳ Describe
 - ☒ **Active**
 - ↳ Supported by
 - ☐ Physical findings
 - ☐ EMG / Nerve Conduction studies
 - ☐ Biopsy
- ☐ History Of
- ☐ Rule out
- ☐ Other

comments

medications

- ↳ **Secondary to Diabetes**
 - ☒ **Yes**
 - ☐ No
- Stroke**
 - ↳ Describe
 - ☐ Active
 - ☒ **History of**
 - ☐ Rule out
 - ↳ Supported by
 - ☒ **Hospitalization**
 - ☐ Image study
 - ☐ Physical findings
 - ☐ Sensory findings
 - ☐ Other

comments

gait/balance issues

- Other**
 - ↳ Describe
 - ☒ **Active**
 - ☐ History of
 - ☐ Rule out
 - ↳ Supported by
 - ☒ **History**
 - ☐ Symptoms
 - ☐ Physical Findings
 - ☒ **Medications**
 - ☐ Test results
 - ☐ Image studies
 - ☐ Biopsy
 - ☐ DME
 - ☐ Other
 - ↳ Other

comments

ADHD

Are you nervous, anxious, feel on the edge or often feel stressed?

☐ Yes ☒ **No**

Do you worry too much about different things?

☐ Yes ☒ **No**

Do you feel afraid that something bad might happen?

☐ Yes ☒ **No**

History of headaches

☐ Yes ☒ **No**

History of auditory hallucinations

☐ Yes ☒ **No**

History of visual hallucinations

☐ Yes ☒ **No**

History of psychotic behavior

☐ Yes ☒ **No**

History of episodes of delirium

☐ Yes ☒ **No**

Do you follow a special diet?

☒ **Yes** ☐ No

Do you have any weakness or deformity in your arms or legs that limits your ability to get around or do what you want to do?

- ☐ Yes ☒ No
 Do you have trouble swallowing your food?
- ☐ Yes ☒ No
 Do you have trouble making people understand you when you speak?
- ☐ Yes ☒ No
 Do you have trouble understanding what people say to you?
- ☐ Yes ☒ No
 Do your hands shake?
- ☐ Yes ☒ No
 Do you have convulsions and seizures?
- ☐ Yes ☒ No
 Do you have trouble with your memory?
- ☐ Yes ☒ No
 Do you have trouble finding words?
- ☐ Yes ☒ No
 Do you have trouble sleeping?
- ☐ Yes ☒ No
 Have you lost your appetite
- ☐ Yes ☒ No
 Do you hear voices or see things that other people do not
- ☐ Yes ☒ No
 Do you have highs and lows
- ☐ Yes ☒ No
 Do you ever feel like someone is out to get you
- How often do you go out to meet with family or friends
☒ Often ☐ Sometimes ☐ Never

comments

member states her family members will come see her but she has been reluctant to go outside during the pandemic

GPCOG Score or MMSE Score

GPCOG Score	or MMSE Score

If GPCOG or MMSE is not done, is

- ☒ Yes ☐ No
 Patient oriented to person
- ☒ Yes ☐ No
 Patient oriented to place
- ☒ Yes ☐ No
 Patient oriented to time
- ☒ Good ☐ Poor
 Recall
- ☒ Yes ☐ Partially ☐ No
 Patient describes recent news event

Affect

- ☒ Normal
- ☐ Abnormal

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things	Not at all	Several Days	More than half the days	Nearly every day
Feeling down, depressed or hopeless	Not at all	Several Days	More than half the days	Nearly every day

PHQ 2 Score

- ☒ < 3
- ☐ 3 or more

Speech

- ☒ Normal
- ☐ Slurred
- ☐ Aphasic
- ☐ Apraxia

Finger to Nose

- ☒ Normal
- ☐ Abnormal

Heel (Shin) to Toe

- ☒ Normal
- ☐ Abnormal

Thumb to Finger Tips

- ☒ Normal
- ☐ Abnormal

Sitting to Standing

- ☒ Normal
- ☐ Needs Assistance
- ☐ Unable

Facial / Extremity Movement

- ☐ Motor Tic
- ☐ Vocal Tic
- ☐ Benign (Essential Tremor)
- ☐ Intention Tremor
- ☐ Non-Intention (Pill rolling) Tremor
- ☐ Rigidity
- ☐ Spasticity
- ☐ Chorea Movement
- ☐ Cog wheeling
- ☒ Normal

Gait

- ☐ Normal
- ☐ Limp
- ☐ Wide based
- ☐ Abductor lurch
- ☐ Paretic
- ☐ Shuffling
- ☐ Ataxic
- ☐ Other (Findings may also apply to Musculoskeletal diagnoses)

comments

slowed (uses cane)

Genitourinary Problems (Overactive Bladder, Urinary Incontinence Stress Incontinence, Benign Prostatic Hypertrophy, Others)

- ☒ Yes
- ☐ No

Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Acute Renal Failure | <input type="checkbox"/> BPH |
| <input checked="" type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> ESRD |
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Frequent UTI |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Nephritis or Nephrosis |
| <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Other |
- Chronic Kidney Disease**
- Describe
 - ☒ **Active**
 - Supported by
 - ☒ **Lab tests**
 - What stage
 - ☐ 1 [GFR > 89]
 - ☐ 2 [GFR 60-89]
 - ☒ **3 [GFR 30-59]**
 - ☐ 4 [GFR15-29]
 - ☐ 5 [GFR <15]
 - Secondary to Diabetes
 - ☒ **Yes**
 - ☐ No
 - Secondary to Hypertension
 - ☒ **Yes**
 - ☐ No

History of frequency

- ☒ **Yes** ☐ No
- ☒ **3x / day**
☐ 4x / day
 ☐ 5x / day
 - ☐ >5x / day

History of Nocturia

- ☐ Yes ☒ **No**

History of Hesitancy

- ☐ Yes ☒ **No**

Do you have trouble urinating?

- ☐ Yes ☒ **No**

Do you ever have blood in your urine?

- ☐ Yes ☒ **No**

Do you have any weakness or deformity in your arms or legs that limits your ability to get around or do what you want to do?

- ☐ Yes ☒ **No**

Do you have trouble holding your urine?

- ☐ Yes ☒ **No**

Do you trouble getting to the bathroom on time?

- ☐ Yes ☒ **No**

Do you ever have pain or burning during urination?

- ☐ Yes ☒ **No**

Do you ever wear pads or diapers?

- ☒ **Yes** ☐ No

comments

wears pad for leakage

Do you have a vaginal discharge?

- ☐ Yes ☒ **No**

Do you have vaginal bleeding?

- ☐ Yes ☒ **No**

Musculoskeletal Problems (Spinal Stenosis, Rheumatoid Arthritis, Gout, Osteoporosis, Others)

☒ Yes

☐ No

Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Collagen (Connective) Tissue Disease | <input type="checkbox"/> Degenerative Disc Disease |
| <input type="checkbox"/> Extremity Fracture (other than Hip) | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Hallux Valgus | <input type="checkbox"/> Hammer Toes |
| <input type="checkbox"/> Onychomycosis | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Pyogenic Arthritis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Spinal Stenosis | <input type="checkbox"/> Systemic Lupus Erythematosus |
| <input type="checkbox"/> Tinea Pedis | <input checked="" type="checkbox"/> Other |

comments

carpal tunnel syndrome

Other

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

☒ History

☐ Symptoms

☐ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

comments

DME (wrist braces)

Other

History / Finding of non- extremity Fracture

☐ Yes

☒ No

History / Finding of Hip Fracture / Dislocation

☐ Yes

☒ No

History / Finding of Vertebral Fracture

☐ Yes

☒ No

Do you have any swelling of your joints?

☐ Yes

☒ No

Do you experience stiffness in the morning or during the day?

☐ Yes

☒ No

Do you have pain in your joints?

☐ Yes

☒ No

Do you have a problem straightening any joints?

☐ Yes

☒ No

Does pain and or swelling in your joints limit your activities?

☐ Yes

☒ No

Have you broken bones(fractures) in any parts of your body?

☐ Yes

☒ No

Do you have constant pain in your bones?

☐ Yes

☒ No

Have you had an amputation?

☐ Yes

☒ No

Integument Problems (Eczema, Psoriasis, Dermatitis, Urticaria, Other)

☐ Yes

☒ No

Endocrine Problems

☒ Yes

☐ No

Diagnoses

- ☒ Chronic Kidney Disease secondary to Diabetes
- ☐ Cushing’s Disease
- ☒ Diabetic Retinopathy
- ☒ Hypertension and Diabetes
- ☐ Hypothyroidism
- ☒ Peripheral Neuropathy secondary to Diabetes
- ☐ Hyperparathyroidism
- ☒ Coronary Artery Disease and Diabetes
- ☒ Diabetes
- ☐ Secondary Hyperparathyroidism
- ☐ Hyperthyroidism
- ☐ Kidney Stone
- ☐ Peripheral Vascular Disease secondary to Diabetes
- ☐ Other

Chronic Kidney Disease secondary to Diabetes

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Decreased GFR

☐ Albuminuria

☐ Elevated BUN/ Creatinine

☐ Dialysis

☐ Other

Patient on ACE or ARB

☒ Yes

☐ No

Coronary Artery Disease and Diabetes

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ History

☒ Medications

☐ Biopsy

☐ Symptoms

☐ Test results

☐ DME

☐ Physical Findings

☐ Image studies

☐ Other

Is patient on a statin

☒ Yes

☐ No

Is patient on an aspirin

☒ Yes

☐ No

Diabetes

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Symptoms

☐ Medications

☐ Physical findings

☒ Lab tests

☒ Other

comments

last A1c 7.5%

Other

Describe

comments

her FBG 178mg/dl this morning - states she ate too late last night. Her usual BG range is 140-170mg/dl

Type

☐ Type 1

☒ Type 2

☐ Gestational

comments

gestational diabetes with 2nd pregnancy

↳ **Most recent Hb A1C, value**

comments

7.50%

↳ **And Date**

comments

Jun-21

↳ **Met with a nurse or dietician for diabetic education**

☐ Yes

☒ **No**

↳ **Met with a diabetic educator**

☐ Yes

☒ **No**

Diabetic Retinopathy

↳ **Describe**

☒ **Active**

☐ History of

☐ Rule out

↳ **Supported by**

☐ Funduscopy exam

☒ **Vision loss**

☐ Laser Therapy

☐ Retinal Injections

☐ Surgical procedure

☐ Other

↳ **Patient sees Ophthalmologist**

☐ Occasionally

☐ Once a year

☒ **Twice a year**

☐ >Twice a year

Hypertension and Diabetes

↳ **Describe**

☒ **Active**

☐ History of

☐ Rule out

↳ **Supported by**

☒ **History**

☐ Symptoms

☐ Physical Findings

☒ **Medications**

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

↳ **Is patient on Ace or ARB**

☒ **Yes**

☐ No

Peripheral Neuropathy secondary to Diabetes

↳ **Describe**

☒ **Active**

☐ History of

☐ Rule out

↳ **Supported by**

☐ Physical exam

☐ Skin lesions

☐ Foot deformity

☐ Surgical procedures

☐ Other

comments

medications

↳ **Patient sees Podiatrist**

☒ **Yes**

☐ No

↳ **How often**

☒ **Once a year**

☐ Twice a year

☐ Quarterly

Do you periodically experience shakiness, lightheadedness, sweating, confusion, or blurred vision?

☐ Yes

☒ **No**

Do you often feel thirsty?

☐ Yes

☒ **No**

Do you have numbness or burning in your legs or feet?

☒ **Yes**

☐ No

Do you get pains in your leg or feet when you walk?

☒ **Yes**

☐ No

Do you get ulcers on your legs or feet?

☐ Yes

☒ No

Do you feel sluggish?

☐ Yes

☒ No

Do you sweat a lot or constantly feel hot?

☐ Yes

☒ No

Have you been told your kidneys are not working right, failing or shutting down?

☒ Yes

☐ No

Have you ever had dialysis?

☐ Yes

☒ No

Is your skin itchy?

☐ Yes

☒ No

Do you test your blood sugar?

☒ Yes

☐ No

comments

checks BG twice daily

Have you lost weight in the past 6 months?

☒ None

☐ 5lbs

☐ 10lbs

☐ 15lbs

☐ More than 15lbs

☐ 10% of your weight
(calculated by assessor)

Hematology / Immunology / Infection Disease Problems (Anemia, easy bruising or abnormal bleeding Thrombocytopenia , Other)

☒ Yes

☐ No

Diagnoses

☐ AIDS

☒ Anemia

☐ C. Difficile

☐ Community Acquired MRSA Infection

☐ HIV

☐ Herpes Zoster

☐ Hospital Acquired MRSA Infection

☐ Immune Deficiency

☐ Leukemia

☐ Lymphoma

☐ Multiple Myeloma

☐ Sepsis

☐ Sickle Cell Disease

☐ Sickle Cell Trait

☐ Thalassemia

☐ Thrombocytopenia

☐ Tuberculosis

☒ Vitamin D Deficiency

☐ Other

Anemia

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Lab tests

☐ Symptoms

☐ History of blood transfusion

☐ Other

comments

medications

Etiology

☒ Iron deficiency

☐ Pernicious

☐ Kidney disease

☐ Hemolysis

☐ Aplastic

☐ Chemotherapy

☐ Blood loss

☐ Chronic Disease

☐ Folate Deficiency

☐ Other

comments

iron deficiency anemia secondary to CKD

- ↳ If yes, Patient on

☒ Iron

☐ B 12

☐ Folic Acid

☐ Blood Transfusions

☐ Other
- Vitamin D Deficiency
- ↳ Describe

☐ Active

☒ History of

☐ Rule out
- ↳ Supported by

☒ Labs

☐ Medications

☐ History

☐ Other

comments

no longer takes medications

Easy bruising or abnormal bleeding

- ☐ Yes
- ☒ No

Long term anticoagulation use

- ☒ Yes
- ☐ No

- ↳ Describe

☐ Aspirin

☐ Coumadin

☐ Thrombin Inhibitors (Pradaxa)

☐ Plavix

☐ Factor Xa Inhibitors (Xarelto, Eliquis)

☐ Other

comments

ASA

Cancer

Diagnosis of Cancer	Yes	No
---------------------	-----	----

Pain

Does the patient experience pain?

- ☒ Yes
- ☐ No

Is the Pain Acute?

- ☐ Yes
- ☒ No

Is the Pain Chronic?

- ☒ Yes
- ☐ No

- ↳ Describe

☒ Active

☐ History of

☐ Rule out
- ↳ Where

tops of feet, wrists from carpal tunnel

- ↳ Do you take Methadone

☐ Yes

☒ No

- ↳ What drug/s do you take for it

tylenol, lyrica

- ↳ How bad is your pain on a scale of one to ten with one being very mild and ten being severe

0

Is the Patient Undergoing Pain Management Planning?

☒ Yes ☐ No

comments

lyrica

Is the Patient Responding to the Pain Management Plan?

☒ Yes ☐ No

Was the patient advised regarding the potential for dependence?

☒ Yes ☐ No

Is there any evidence of Maladaptive Behavior?

Tolerance?

☐ Yes ☒ No

Withdrawal?

☐ Yes ☒ No

Increased usage over a longer period that intended?

☐ Yes ☒ No

Desire or unsuccessful effort to cut down on use?

☐ Yes ☒ No

Excess time spent in activities to obtain the substance?

☐ Yes ☒ No

Continued use despite Doctor advice or patient knowledge of habituation?

☐ Yes ☒ No

Physical or Psychological Problem related to the substance use?

☐ Yes ☒ No

Vital Signs

Vital Signs

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
138 (mmHG)	88 (mmHG)	73 (bpm)	18	97.4	99	0

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	3 (Inch)	205 (lbs)	36.3

☐ Obesity (BMI 30 – 34.9) ☒ **Moderate Obesity (BMI 35 – 39.9)** ☐ Morbid Obesity (BMI = or > 40)

☐ Malnutrition (BMI < 18.5)

Exam Review

Constitutional

General appearance:	Normal	Abnormal
---------------------	--------	----------

Head and Face

Examination of head and face:	Normal	Abnormal
Palpation of the face and sinuses:	Normal	Abnormal

Eyes

Inspection of conjunctiva and lids:	Normal	Abnormal
Examination of pupils and irises:	Normal	Abnormal

Ears, Nose, Mouth and Throat

External Inspection of ears and nose:	Normal	Abnormal
Otoscopic examination:	Normal	Abnormal
Assessment of hearing:	Normal	Abnormal
Inspection of nasal mucosa, septum and trubينات:	Normal	Abnormal
Inspection of lips, teeth and gums:	Normal	Abnormal

Comment:

all teeth without dental caries

Examination of oropharynx:	Normal	Abnormal
----------------------------	--------	----------

Neck

Examination of neck:	Normal	Abnormal
Examination of thyroid:	Normal	Abnormal

Comment:

non-palpable

Pulmonary

Assessment of respiratory effort:	Normal	Abnormal
Percussion of chest:	Normal	Abnormal

Comment:

deferred

Palpation of chest:	Normal	Abnormal
Auscultation of lungs:	Normal	Abnormal

Cardiovascular

Palpation of heart:	Normal	Abnormal
---------------------	--------	----------

Comment:

deferred

Auscultation of heart:	Normal	Abnormal
Carotid Arteries:	Normal	Abnormal
Abdominal Aorta:	Normal	Abnormal

Comment:

abd. Soft, nontender

Pedal Pulses:	Normal	Abnormal
Examination of Arterial Pulses:	Normal	Abnormal

Comment: PAD testing performed

Examination of Edema / Varicosities:	Normal	Abnormal
--------------------------------------	--------	----------

Lymphatic

Palpation of cervical nodes (neck)	Normal	Abnormal
Palpation of preauricular nodes (in front of the ears)	Normal	Abnormal
Palpation of Submandibular nodes (under jaw line/chin)	Normal	Abnormal

Musculoskeletal

Examination of gait and station:	Normal	Abnormal
Inspection/palpation of digits and nails:	Normal	Abnormal
Inspection/palpation of joints, bones and muscles:	Normal	Abnormal

Comment: left great toe amputation

Assessment of range of motion:	Normal	Abnormal
Assessment of stability:	Normal	Abnormal
Assessment of muscle strength/tone:	Normal	Abnormal

Skin

Inspection of skin and subcutaneous tissue:	Normal	Abnormal
Palpation of skin and subcutaneous tissue:	Normal	Abnormal

Neurologic

Indicate specific cranial nerve tested

grossly intact

Indicate cranial nerve deficits found

na

Romberg Test	Normal	Abnormal
--------------	--------	----------

Comment: deferred

Examination of reflexes:	Normal	Abnormal
Examination of sensation:	Normal	Abnormal
Coordination:	Normal	Abnormal

Diabetes

Foot Exam:	Normal	Abnormal
------------	--------	----------

☐ RFoot

☒ LFoot

☐ Bilateral

Comments: 1st digit amputation

Psychiatric

Description of patient's judgement / insight:	Normal	Abnormal
Orientation of person, place and time:	Normal	Abnormal
Recent and remote memory:	Normal	Abnormal
Mood and affect:	Normal	Abnormal

Screenings Needed

Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnosis	Comments
DIGITAL_RETINAL_EXAM	No	Completed Kit with Member			Yes	07-08-2021	too dark images	type 2 diabetes; cataract; diabetic retinopathy	
HBA1C	No	Left Kit	77000628	77000628	Select				
MICROALBUMIN	No	Left Kit	37239623	37239623	Select				
FOBT	Yes	Left Kit	330278977	330278977	Select				
DEXA	No	Select			Select				
PAD	No	Completed Kit with Member			Yes	07-08-2021	Rt foot=0.60 (moderate)	type 2 diabetes mellitus with complications; diabetic peripheral neuropathy	discussed results with member
LDL	N/A	Select			Select		Lt foot=0.41 (significant)		

Mini-Cog

39. Mini- Cog (see attached sheet)

Step 1: Three Word Registration

Look directly at person and say, "Please listen carefully. I am going to say three words that I want you to repeat back to me now and try to remember. The words are [select a list of words from the versions below]. Please say them for me now." If the person is unable to repeat the words after three attempts, move on to Step 2 (clock drawing).

The following and other word lists have been used in one or more clinical studies.1-3 For repeated administrations, use of an alternative word list is recommended.

Version 1	Version 2	Version 3	Version 4	Version 5	Version 6
Banana	Leader	Village	River	Captain	Daughter
Sunrise	Season	Kitchen	Nation	Garden	Heaven
Chair	Table	Baby	Finger	Picture	Mountain

Step 2: Clock Drawing

Say: "Next, I want you to draw a clock for me. First, put in all of the numbers where they go." When that is completed, say: "Now, set the hands to 10 past 11."

Use preprinted circle (see next page) for this exercise. Repeat instructions as needed as this is not a memory test.

Move to Step 3 if the clock is not complete within three minutes.

Step 3: Three Word Recall

Ask the person to recall the three words you stated in Step 1. Say: "What were the three words I asked you to remember?" Record the word list version number and the person's answers below.

Word List Version : 1

Person's Answers: village, baby, dog

Word Recall :	3 Points	1 point for each word spontaneously recalled without cueing. Home Safety Yes
Clock Draw :	2 Points	Normal clock = 2 points. A normal clock has all numbers placed in the correct positions) with no missing or duplicate numbers. Hands are pointing to the 11 sequence and approximately correct position (e.g., 12, 3, 6 and 9 are in anchor Inability or refusal to draw a clock (abnormal) = 0 points.and 2 (11:10). Hand length is not scored.
Total Score :	5 Points	Total score = Word Recall score + Clock Draw score. A cut point of < 3 on the Mini-Cog™ has been validated for dementia screening, but many individuals with clinically meaningful cognitive impairment will score higher. When greater sensitivity is desired, a cut point of < 4 is recommended as it may indicate a need for further evaluation of cognitive status.

Home Safety & Personal Goals

40. In the past year how many times have you Fallen?

- ☐ None
- ☒ Once
- ☐ Twice
- ☐ Three times
- ☐ More than three times

- ☒ Do you worry about falling or feeling unsteady when standing or walking
- ☐ Yes
- ☒ No
- ☒ Worries about falling or feeling unsteady when standing or walking?
- ☐ Yes
- ☒ No
- ☒ Did you have a fracture in past 6 months?
- ☐ Yes
- ☒ No

41. Home Safety

a. Do you have obstacles in the house, loose small rugs or objects on the floor that could cause tripping?	Yes	No
b. Do you have electrical cords running across floors, in doorways or under a rugs?	Yes	No
c. Do you have no slip mats on the shower floor or bath tub?	Yes	No
d. Do have adequate lighting in hallways and on the stairs?	Yes	No
e. Do you have handrails on staircases?	Yes	No
f. Is your hot water heater set for a maximum of 120 degrees?	Yes	No
g. Do you have smoke detectors on each level of the house and in	Yes	No

all sleeping a rooms?		
h. Do you have carbon Monoxide detectors on each level of the house?	Yes	No
i. Have used established an escape route in the event of fire?	Yes	No

42. Are there things about yourself you wish you could change or improve?

not asked

43. Is there anything that you could do to improve your quality of life?

not asked

44. Have you ever physically or felt emotionally abused by someone

☐ Yes

☒ No

45. Feeling like harming others or yourself

☐ Yes

☒ No

46. Are you afraid of anyone or is anyone hurting you?

☐ Yes

☒ No

Patient Summary

Assessors Comments :


56yo female that lives alone in apartment setting. She wishes to get out of her current residence because of the drug traffic within her building. She is a former user, recovered in 2003, sees psychiatrist for ADD. She had a stroke in February 2020 for which she received PT/OT services. She fell last week looking at her phone and not paying attention to where she was walking. Preventative care discussed in length with member. She is doing well and voices no complaints or needs from her insurance company. PAD testing & retinal images obtained (images were too dark) - member verbalizes understanding the importance of follow-up care with ophth for eye dilatation. She eats a well-balanced diet and checks her BG twice daily.

COPD is in previous documented conditions; however, member denies this history.

Member Acknowledgment

I have been advised by the evaluator and understand that the services performed by the evaluator are limited to the evaluation performed today; the evaluator has no further duties to me once the evaluation performed today is completed ; the evaluator is not liable for abandonment my refusing to provide me treatment or continuing care to me beyond this evaluation; and I should contact my primary care or treating physician for all questions and concerns regarding medical care and treatment or, in the event of an emergency, call 911

Member informed of acknowledgment	<input checked="" type="checkbox"/>
Date/Time of Service/Evaluation :	2021-07-08T20:14

Time exam finished	
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Provider Signature	<div><div>Digitally signed by Brittney Walls, FNP 2021-07-21, 14:09</div></div>
Addendum	

Disclosure Statement

Your health plan, has contracted with Focus Care to conduct a health exam on all of its Medicare members, including you. The health exam includes questions to help your health plan learn more about your current health. The exam may also find things that could effect your health. The results of the exam will help your health plan and your doctor keep you as healthy as possible.

Personal health information, or PHI, is information in your medical record that identifies the record as your record. PHI includes things like your date of birth, age, address, telephone number, and your medical history.

Most of the time, Focus Care will not release your personal information without your permission. Measures are in place to prevent your personal information from being accidentally released in writing, including by use of a computer, or orally. You may request more information about how your personal information is protected.

There are times when Focus Care is allowed to release your personal information without your permission. For example, your medical information may be given to other health care providers who take care of you. The results of this exam will be sent to your health plan and to your doctor.

Focus Care may release your personal health information to a 'business associate'. A 'business associate' is another agency that Focus Care uses to do things, such as billing. We require our 'business associates' to have security measures in place to prevent your personal information from being accidentally released in writing, including by use of a computer, or orally.

Focus Care may be required to release your personal health information, without your permission, by law. including statutes, regulations, or valid court orders.

Focus Care will obtain your permission to use or release your personal health information for any other reason.

Do you have any questions about this information? Would you like to receive this information in a different language?

Your agreement to have this medical exam means you have given your permission to Focus Care to release the results of your medical exam to your health plan and to your doctor. Do you agree?