

HRA Form

Plan :	VPHP - VIRGINIA PREMIER
Program :	MEDICARE
LOB :	DSNP
Region :	CENTRAL
Aligned :	N
Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	JUDITH L AUSTIN
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1956-04-16
Evaluation Date :	
Visit Type :	In Person

Demographics	
Name	JUDITH L AUSTIN
Gender	Female
Address	1309 NEW MARKET RD
City	HENRICO
State	VA
Zip	23231-2754
Date of Birth	1956-04-16
Age(as of date)	65
Marital Status	Single
Member Identification Number	11000913
HICN	4RC4C63VK78
Phone Number	8046177937
Cell Number	8042263868
Email	
Emergency Contact	Dennis Stanly
Phone Number	8046177937
Primary Care Physician	Amanda George
Phone Number	8048280951
PCP Address	4744 FINLAY ST
PCP City	HENRICO

PCP State	VA
PCP Zip	232312754
PCP County	HENRICO
Office ID	P9120120
Office Name	EAST END PEDIATRICS

Covid Screening

In the last 14 days, have you:

Traveled internationally?

Answer: No

Had known exposure to anyone diagnosed with Corona virus (COVID-19)

Answer: No

Had close contact with someone who has traveled to a high risk area?

Answer: No

Developed Fever?

Answer: No

Developed Cough?

Answer: No

Developed Flu like symptoms?

Answer: No

Developed Shortness of breath?

Answer: No

Self-Assessment and Social History

13. Tobacco use

Answer: Former

Type

Answer:Cigarettes

How Many

Answer: 1 pack

14. Alcohol Use

Answer: Former

How many drinks	How Often
1	Week

Activities of Daily Living

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

A. Getting in or out of bed

Answer: No

B. Getting in or out of chairs

Answer: No

C. Toileting

Answer: No

D. Bathing

Answer: No

E. Dressing

Answer: No

F. Eating

Answer: No

G. Walking

Answer: No

H. Going up or down stairs

Answer: No

Medical History

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

Answer: Cane

21. Are you currently seeing any specialists?

Answer: Yes

Medical Specialty	Specialist	For
Cardiologist	Dr. Roa	Heart failure
Neurologist	Dr. Ward	Hydrocephalus
Pulmonologist	Dr. West	emphysema
Psychiatrist	Kaska Rebekah, NP	Eplipsy

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

A. Seen your PCP

Answer: 5 or more

B. Visited the Emergency Room

Answer: None

C. Stayed in the hospital overnight

Answer: None

D. Been in a nursing home

Answer: None

E. Had Surgery

Answer: None

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

Physical Therapist

Answer: No

Occupational Therapist

Answer: No

Dietician

Answer: No

Social Worker

Answer: No

Pharmacist

Answer: Yes

Speech Therapist

Answer: No

Chiropractor

Answer: No

Personal Care Worker (HHA, CNA, PCA)

Answer: No

Meals on Wheels

Answer: No

25. In the past two years have you received any of the treatments below?

Chemotherapy

Answer: No

Catheter Care

Answer: No

Oxygen

Answer: Yes

Wound Care

Answer: No

Regular Injections

Answer: No

Tube Feedings

Answer: No

Family History

26. Family History

Answer: Yes

Family Member	Medical Condition	Cause of Death
Father	COPD	Heart Failure
Mother	Rheumotoid Arthritis	Alive

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	No
Breast Exam/Mammography	Yes
Cervical Screening	Yes
Bone Density	Yes
Prostate Exam/PSA	Not Applicable
If Diabetic Eye Exam	No
If Diabetic Foot Exam	Yes
If Diabetic Hgb A1c screen	Yes
Lipid Panel	Yes

Allergies / Medications

35. Allergies

Answer: yes

Substance	Reaction
sulfur	GI upset, itching
narcotics	GI upset
latex	itching

37. Chronic Use of

Answer: ASA , Steroids , Anticoagulants

38. Medication Compliance and Knowledge of Use and Disease

1. Do you ever forget to take your medicine?

Answer: No

2. Do you sometimes not pay enough attention to your medication?

Answer: No

3. Do you know the longterm benefit of taking your medicine as told to you by the doctor or pharmacist?

Answer: No

4. When you feel better do you sometimes stop taking your medicine?

Answer: No

5. Sometimes if you feel worse when you take your medicine do you stop taking it?

Answer: No

6. Do you sometimes forget to refill your prescription on time?

Answer: No

Review of Systems and Diagnoses

EYES

Eye Problems (Glaucoma, Cataracts, Macular Degeneration, Blindness, Retinal Detachment, Other)

Answer: Yes

Diagnoses

Cataracts

Describe

Answer: History of

Supported by

Answer: History

Comment: Bilateral Cataract removal 2018

Secondary to Diabetes

Answer: Yes

Do you wear glasses or contacts?

Answer: Yes

Do you have trouble seeing even with glasses?

Answer : Yes

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

Answer : No

Do you have problems seeing at night?

Answer: Yes

Do you have eye pain?

Answer: Yes

Which Eye?

Answer : Both

Do you have problems with tearing?

Answer: Yes

Comment: Bilateral Eye Tearing

Do you have a problem with dry eye?

Answer: No

EARS

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

Answer: No

NOSE

Nose Problems (Nose Bleeds, Sinus infections, Other)

Answer: No

MOUTH AND THROAT

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

Answer:

NECK

Neck Problems (parotid Disease, Carotid Stenosis, Other)

Answer: No

RESPIRATORY

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

Answer: Yes

Comment: Emphesema

Diagnoses

Asthma

Describe

Answer: Active

Supported by

Answer: Wheezing, Chronic Cough, Use of Bronchodilator, Use of Inhaled or oral steroids

Is patient on controller medications

Answer: Yes

Does patient use rescue medications

Answer: Yes

Does patient have current exacerbation

Answer: No

COPD

Describe

Answer: Active

Supported by

Answer: Wheezing, O2 use

Has patient been told they have Chronic Bronchitis

Answer: No

Has patient been told they have Emphysema

Answer: Yes

Is patient on Bronchodilator

Answer: Yes

Route is

Answer: Inhaled

Is patient on Steroids

Answer: Yes

Route is

Answer: Inhaled

Does patient have current exacerbation

Answer: No

Use of Oxygen

Answer: Yes

Describe

Answer : Continuous

Litres / Min

Answer : 2.5Liter

Shortness of breath

Answer: Yes

Wheezing

Answer: Yes

Chronic Cough

Answer: Yes

Patient requires durable medical equipment

Answer: Yes

CARDIOVASCULAR

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

Answer: Yes

Diagnoses

Angina

Describe

Answer: Active

Supported by

Answer: Medications

Describe

Answer: Stable

Congestive Heart Failure

Describe

Answer: Active

Supported by

Answer: Medications

Describe

Answer: Unknown

Secondary to Hypertension

Answer: Yes

Is patient on an ACE or ARB

Answer: Yes

Is patient on a Beta Blocker

Answer: No

Deep Vein Thrombosis

Describe

Answer: Chronic

Describe

Answer: Rule out

Supported by

Answer: Use of anticoagulation

Use of anticoagulation

Describe

Answer: Therapeutic

Persistent for three months or more

Answer: Yes

Hyperlipidemia

Describe

Answer: History of

Supported by

Answer: Medication

Comment: no longer takes medication per member

Is patient on Statin

Answer: No

Hypertension

Describe

Answer: Active

Supported by

Answer: Medications

Adequately controlled

Answer: Yes

History of Chest Pain

Answer: Yes

Pain described as

Answer : Achy

Does pain go into left arm

Answer : Yes

Is pain reproduced or worsened when touching chest or costochondral junctions

Answer : No

Is pain brought on by

Answer : Other

Describe

Answer : While sitting

Is pain relieved by oral medication

Answer : Yes

How long before pain is relieved

Answer : 1 min

What medication / s

Answer : Nitroglycerin

History of Intermittent Claudication

Answer: No

Implanted Pacemaker

Answer: No

Implanted Defibrillator

Answer: No

Do you have abnormal heart beats?

Answer: Yes

Does your heart race?

Answer: Yes

Do you sleep on more than one pillow?

Answer: Yes

have you ever have fluid in your lungs?

Answer: Yes

Do your legs or ankles swell up?

Answer: Yes

Do you follow a special diet?

Answer: Yes

Do you have headaches?

Answer: Yes

Do you feel light headed when you stand up?

Answer: Yes

GASTROINTESTINAL

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

Answer: Yes

Diagnoses

GERD

Describe

Answer: Active

Supported by

Answer: Medications

History of blood in stool

Answer: Yes

Comment: Yes rectal cancer history, member states she will be goin to the rectal surgwon

History of black stools

Answer: Yes

History of Heartburn / Dyspepsia

Answer: Yes

Describe

Answer : Chronic

History of Vomiting or Regurgitation

Answer: No

History of pain after eating

Answer: Yes

Describe

Answer : Epigastric

History of Jaundice

Answer: No

Do you follow a special diet?

Answer: No

Do you have frequent abnormal abdominal pain?

Answer: No

Do you have intermittent nausea or vomiting?

Answer: No

Do you have trouble with constipation?

Answer: Yes

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

Answer: No

Do you see blood in your urine?

Answer: No

Do you have Frequent Stomach Pain

Answer: No

NEURO-PSYCH

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

Answer: Yes

Diagnoses

Depression

Describe

Answer: Active

Supported by

Answer: Use of antidepressant medication

Major

Answer: Yes

Supported by

Answer: Chronic use of antidepressant medication beyond 6 months

Seizure Disorder

Describe

Answer: Active

Supported by

Answer: History of recurrent seizures, Medications

Comment: 1 seizure per month reported by member which has decrease since her new medication

Other

Describe

Answer: Active

Supported by

Answer: Medications

Other

Answer: Anxiety

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

Answer: Yes

Do you worry too much about different things?

Answer: Yes

Do you feel afraid that something bad might happen?

Answer: Yes

History of headaches

Answer: Yes

Symptoms with headaches of

Answer : Sensitivity to light / sound

History of auditory hallucinations

Answer: No

History of visual hallucinations

Answer: No

History of psychotic behavior

Answer: No

History of episodes of delirium

Answer: No

Do you follow a special diet?

Answer: 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?

Answer: No

Do you have trouble swallowing your food?

Answer: Yes

Do you have trouble making people understand you when you speak?

Answer: No

Do you trouble understanding what people say to you?

Answer: No

Do your hands shake?

Answer: Yes

Comment: right hand, currently being evaluated for essential tremors per member

Do you have convulsions and seizures?

Answer: Yes

Comment: once a mode

Do you have trouble with your memory?

Answer: Yes

Do you have trouble finding words?

Answer: No

Do you have trouble sleeping?

Answer: Yes

Have you lost your appetite

Answer: No

Do you hear voices or see things that other people do not

Answer: No

Do you have highs and lows

Answer: Yes

Do you ever feel like someone is out to get you

Answer: No

GPCOG Score or MMSE Score

GPCOG Score	
or MMSE Score	

GENITOURINARY

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

Answer: No

MUSCULOSKELETAL

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

Answer: Yes

Diagnoses

Degenerative Disc Disease

Describe

Answer: Active

Supported by

Answer: Medications

Normal bladder and bowel function

Answer: No

Site of disease

Answer: Lumbar

History / Finding of non- extremity Fracture

Answer: No

History / Finding of Hip Fracture / Dislocation

Answer: No

History / Finding of Vertebral Fracture

Answer: No

Do you have any swelling of your joints?

Answer: No

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

Answer: Yes

Do you have pain in your joints?

Answer: Yes

Comment: chronic back pain

Do you have a problem straightening any joints?

Answer: No

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

Answer: No

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

Answer: No

Do you have constant pain in your bones?

Answer: Yes

Comment: chronic back pain

Have you had an amputation?

Answer: No

INTEGUMENT

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

Answer: Yes

Diagnoses

Other

Describe

Answer: Active

Supported by

Answer: Physical Findings, Other

Other

Describe

Answer: Back Growth Present member will be getting evaluated by dermatologist .

Other

Answer:

Do you have ulcers or wounds that require dressings?

Answer: No

Do you have a chronic skin condition?

Answer: No

Does your skin problem require the use of chronic medication, cream or ointment?

Answer: No

Do you get pains in your legs when you walk that make you stop to get relief?

Answer: No

Do you have skin breakdown or ulcers around your ankles?

Answer: No

ENDOCRINE

Endocrine Problems

Answer: Yes

Diagnoses

Diabetes

Describe

Answer: Active

Supported by

Answer: Medications

Type

Answer: Type 2

Most recent Hb A1C, value

Answer: Unknown

And Date

Answer: Unknown

Met with a nurse or dietician for diabetic education

Answer: No

Met with a diabetic educator

Answer: No

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

Answer: Yes

Comment: Sweating and shaking

Do you often feel thirsty?

Answer: Yes

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

Answer:

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

Answer: No

Do you get ulcers on your legs or feet?

Answer: No

Do you feel sluggish?

Answer: Yes

Do you sweat a lot or constantly feel hot?

Answer: Yes

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

Answer: No

Have you ever had dialysis?

Answer: No

Is your skin itchy?

Answer: Yes

Do you test your blood sugar?

Answer: Yes

HEMATOLOGY / IMMUNOLOGY / INFECTIOUS DISEASE

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

Answer: No

Pain

Vital Signs

Vital Signs

Blood Pressure	146/86 mmHG
Pulse	80 bpm
Respiratory Rate	18
Temp	96.8
Pulse Oximetry	96
Pain Scale /10	0/10

BMI

Comment:

Patients Height	5 feet 8 inch
Patients Weight	258 lbs
BMI	39.2

Obesity Level

Answer: Moderate Obesity (BMI 35 – 39.9)

Exam Review

Screenings Needed

Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnosis	Comments
DIGITAL_RETINAL_EXAM	Yes	Completed Kit with			Select			L: No diabetic Retinopathy R: No diabetic Retinopat	

		Me mb er						hy	
HBA1 C	Yes	Left Kit	77010 610	77010 610	Sele ct				
MICRO ALBUM IN	Yes	Left Kit	37324 371	37324 371	Sele ct				
FOBT	Yes	Left Kit	33022 6873	33022 6873	Sele ct				
DEXA	No	Sel ect			Sele ct				
PAD	No	Sel ect			Sele ct				
LDL	N/A	Sel ect			Sele ct				

Mini-Cog

Word List Version	1
Person's Answers	Leader Season Table
Word Recall	3
Clock Draw	2
Total Score	5

Home Safety & Personal Goals

41. Home Safety

- a. Do you have obstacles in the house, loose small rugs or objects on the floor that could cause tripping?
Answer: No
- b. Do you have electrical cords running across floors, in doorways or under a rugs?
Answer: No
- c. Do you have no slip mats on the shower floor or bath tub?
Answer: Yes
- d. Do have adequate lighting in hallways and on the stairs?
Answer: Yes
- e. Do you have handrails on staircases?

Answer: Yes

f. Is your hot water heater set for a maximum of 120 degrees?
Answer: Yes

g. Do you have smoke detectors on each level of the house and in all sleeping a rooms?
Answer: Yes

h. Do you have carbon Monoxide detectors on each level of the house?
Answer: No

i. Have used established an escape route in the event of fire?
Answer: Yes

42. Are there things about yourself you wish you could change or improve?
Answer: "yes I wish my overall health would improve"

43. Is there anything that you could do to improve your quality of life?
Answer: no

Patient Summary	
Assessors Comments	Member educated on screening and the importance colonoscopy, mammogram and bone scan. Member reminded to comply with her medication administration. Instructed patient to follow diabetic diet and low sodium diet. Member reminded to attend her dermatology appointment for growths noted on her posterior trunk.
Member informed of acknowledgment	true
Date/Time of Service/ Evaluation :	2021-07-14T15:15
Time exam finished	2021-07-14T16:45
Provider Signature	<div><div>Tanya Mirtil AGNP-C</div><div>Digitally signed by Tanya Mirtil, NP 2021-07-14, 21:33</div></div>
Addendum	
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
Disclosure Statement	<div>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.</div> <div>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.</div> <div>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.</div> <div>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.</div> <div>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.</div> <div>Focus Care may be required to release your personal health information, without your permission, by law. including statutes, regulations, or valid court orders.</div> <div>Focus Care will obtain your permission to use or release your personal health information for any other reason.</div> <div>Do you have any questions about this information? Would you like to receive this information in a different language?</div> <div>Your agreement to have this medical exam means you have given your permission to Focus Care to release the</div>

	results of your medical exam to your health plan and to your doctor. Do you agree?
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