

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	WALTER D JORDAN
Evaluator Name :	test clinicianFE, FNP
Assessment Type :	Health Risk Assessment
DOB :	1948-12-01
Evaluation Date :	2021-2-16 10:56 AM
Visit Type :	In Person

Demographics

Plan	VPHP - VIRGINIA PREMIER
Program	Medicare
LOB	DSNP
Name	WALTER D JORDAN
Gender	Male
Address	1702 STAUNTON AVE NW
City	ROANOKE
State	VA
Zip	240179999
Date of Birth	1948-12-01
Age(as of date)	73
Marital Status	Divorced
Member Identification Number	11001318
HICN	2RM7C74GA38
Phone Number	5405952829
Cell Number	
Alternate Contact Number	
Email	
Emergency Contact	Jean Rosser
Phone Number	540-494-4638
Primary Care Physician	TU, PRISCILLA
Phone Number	5404279200
PCP Address	2145 Mount Pleasant Blvd Se
PCP City	Roanoke
PCP State	VA

PCP Zip	240143632
PCP County	
Office ID	P0117344
Office Name	CARILION FAMILY MEDICINE ROANOKE SALEM

1. Race

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

2. Preferred language

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> English | <input checked="" type="checkbox"/> Other | |
| ↳ If other, | | |
| <input checked="" type="checkbox"/> African languages | <input type="checkbox"/> Arabic | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> French | <input type="checkbox"/> French Creole | <input type="checkbox"/> German |
| <input type="checkbox"/> Greek | <input type="checkbox"/> Gujarati | <input type="checkbox"/> Hebrew |
| <input type="checkbox"/> Hindi | <input type="checkbox"/> Hungarian | <input type="checkbox"/> Italian |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean | <input type="checkbox"/> Persian |
| <input type="checkbox"/> Polish | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Scandinavian Languages | <input type="checkbox"/> Serbo-Croatian | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Urdu | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Yiddish | | |

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?

- ☐ Less than 3rd grade
 ☐ Completed 3rd grade
 ☐ Completed 8th grade
 ☒ **Completed 12th grade**
☐ Attended College

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

9. Where do you currently live?

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

comments

lives with cousin - family member

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

comments

Cousin - jean rosse

12. Are you currently a caregiver for someone?

- ☐ Yes
 ☒ **No**

13. Tobacco use

- ☒ **Current**
☐ Former
 ☐ Never
- ↳ **Type**
- ☒ **Cigarettes**
☐ Cigars
 ☐ Chewing Tobacco
- ☐ Vaping
 ☐ Other
- ↳ **How Many**
- ☒ **1 - 3 a day**
☐ 1/2 a pack
 ☐ 1 pack
- ☐ More than 1 pack
 ☐ Other

14. Alcohol Use

- ☐ Current
 ☐ Former
 ☒ **Never**

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

- ☒ **Yes**
☐ No
- ↳ **Which drugs or medication**
- MARIJUNA 1-2 TIMES PER WEEK

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

comments

ENCOURAGED TO DISCUSS WITH PCP

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

Medical History

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

☒ None

21. Are you currently seeing any specialists?

☒ Yes

☐ No

Medical Specialty	Specialist	For
Cardiologist	Goldstein	BRADYCARDIA, NEW PACEMAKER
Psychiatrist	Dana jones - blue ridge	BIPOLAR DISORDER

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

A. Seen your PCP	None	1	2	3	4	5 or more
B. Visited the Emergency Room	None	1	2	3	4	5 or more

[If one or more, describe](#)

MENTAL HEALTH EMERGENCY
LAST VISIT 1/2021 - SUICIAL IDEATION AND WAS ADMITTED TO PSYCH REHAB X 11 DAYS.

C. Stayed in the hospital overnight	None	1	2	3	4	5 or more
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[If one or more, describe](#)

Covid-19 + NOV2019 - 18 DAYS (DENIES INTUBATION)

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

[If one or more, describe](#)

Pacemaker implant JAN 2021

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

☒ Yes

☐ No

[Describe](#)

Coronary Stents 2014 and June 2020

Covid-19 - Nov 2021

Psych rehab for SI - Jan 2021

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

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
Mother		CHF
Father		ALCOHOL - CIRRHOSIS

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	Yes
Breast Exam/Mammography	Not Applicable
Cervical Screening	Don't Know
Bone Density	No
Prostate Exam/PSA	Yes
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

2020

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

comments

2018

↳ Pneumovax

- ☒ Yes
 ☐ No
 ☐ Unknown

↳ Prevenar

- ☐ Yes
 ☐ No
 ☐ Unknown

34. Have you been vaccinated for Herpes Zoster?

- ☐ Yes
 ☒ No

Allergies / Medications

35. Allergies

- ☒ Yes
 ☐ No

Substance	Reaction
ASA	GI BLEEDING
PCN	HIVES

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
2021-02-20	QUETIAPINE	300 MG	PO = By Mouth	HS		Taking	Not Taking
2021-02-20	METOPROLOL	25 MG	PO = By Mouth	AC		Taking	Not Taking
2021-02-21	LISINAPRIL	20 MG	PO = By Mouth	AC		Taking	Not Taking

2021-02-21	HYDROXYZINE	25 MG	PO = By Mouth	AC		Taking	Not Taking
2021-02-20	FLUOXETINE	60 MG	PO = By Mouth	AC		Taking	Not Taking
2021-02-20	DICYCLOMIN E	20 MG	PO = By Mouth	QID		Taking	Not Taking
2021-02-20	BUPROPION	100 MG	PO = By Mouth	BID		Taking	Not Taking
2021-02-20	SUCRALFAT E	1 GM	Select	BID		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
2. Do you sometimes not pay enough attention to your medication?	Yes	No
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: MAIL ORDER IN PILL PACK PER DAY

Review of Systems and Diagnoses

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

☒ **Yes** ☐ No

Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Difficulty with vision |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hyperopia |
| <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Myopia |
| <input type="checkbox"/> Retinal Disease | <input type="checkbox"/> Others |

Do you wear glasses or contacts?

☐ 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

↳ Diagnoses

☐ Bleeding Gums

☒ Difficulty Chewing

☐ Difficulty Swallowing

☒ Other

Difficulty Chewing

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Because of pain

☐ Yes

☒ No

Other

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☐ History

☐ Symptoms

☒ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

↳ Other

comments

NO TEETH

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

☐ Abnormal Cardiac Rhythm

☐ Aneurysm

☒ Angina

☐ Atrial Fibrillation

☐ Cardio – Respiratory Failure / Shock

☐ Cardiomyopathy

☐ Congestive Heart Failure

☐ 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 |

Angina

Describe

- ☐ Active

Supported by

- ☒ **Medications**

- ☒ **Other**

Other

Describe

History Of

- ☐ Rule out

History characterizing chest pain

- ☐ Stress test

comments

CAD WITH STENTING

Describe

- ☒ **Stable**

- ☐ Unstable

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**

- ☐ Diagnosis of angina

- ☐ Medications

- ☐ History of CABG

- ☐ ECG

- ☐ Other

comments

CAD WITH STENTING X 2

History of Chest Pain

- ☒ **Yes**

- ☐ No

Pain described as

- ☐ Achy

- ☐ Sharp

- ☒ **Tight**

- ☐ Crushing

Does pain go into left arm

☐ Yes ☒ No

↳ Is pain reproduced or worsened when touching chest or costochondral junctions

☐ Yes ☒ No

↳ Is pain brought on by

☐ Exertion ☐ Eating

☐ Other

☒ Stress / Anxiety

↳ Is pain relieved by oral medication

☐ Yes ☒ No

History of Intermittent Claudication

☐ Yes ☒ No

Implanted Pacemaker

☒ Yes ☐ No

↳ Describe

☐ Ventricular

☐ Asystole

☐ Cardiac Arrest

Tachycardia

comments

BRADYCARDIA

↳ Last interrogation date

2/2021

↳ Type and ID number

NOT AVAILABLE

Implanted Defibrillator

☐ Yes ☒ No

Do you have abnormal heart beats?

☒ Yes ☐ No

comments

BRADYACARDIA

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

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

Bowel Movements

☒ Normal ☐ Abnormal

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

- | | |
|---|---|
| <input type="checkbox"/> Alcohol Dependence | <input type="checkbox"/> Amyotrophic Lateral Sclerosis |
| <input checked="" type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Cerebral Hemorrhage |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Delusional Disease |
| <input type="checkbox"/> Dementia | <input checked="" type="checkbox"/> Depression |
| <input type="checkbox"/> Drug Dependence | <input type="checkbox"/> Fibromyalgia |
| <input checked="" type="checkbox"/> Generalized Anxiety Disorder | <input type="checkbox"/> Guillain-Barre Disease |
| <input type="checkbox"/> Hemiparesis | <input type="checkbox"/> Huntington's Chorea |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Intellectual and or Developmental Disability |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Myasthenia Gravis |
| <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Peripheral Neuropathy |
| <input type="checkbox"/> Restless leg syndrome | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Subdural Hematoma |
| <input type="checkbox"/> TIA | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Other | |

Bipolar Disorder

Describe

☒ **Active** ☐ History of ☐ Rule out

Supported by

☐ History of mood swings ☒ **Medication** ☐ Other

Depression

Describe

☒ **Active** ☐ History of ☐ Rule out

Supported by

☐ Symptoms ☒ **PHQ 2 / 9** ☒ **Use of antidepressant medication**

☐ Other

Major

☒ **Yes** ☐ NO

Supported by

☐ PHQ 9 ☐ Hospitalization ☒ **Chronic use of**

antidepressant
medication beyond
6 months

- ☐ Use of ECT
- Generalized Anxiety Disorder
 - ☒ Describe
 - ☒ Active
 - ☐ History of
 - ☐ Rule out
 - ☒ Supported by
 - ☐ Symptoms
 - ☐ GAD 7
 - ☒ Antianxiety medication
 - ☐ Other

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 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
- ☐ **Yes**
☒ **No**
- How often do you go out to meet with family or friends
- ☒ **Often**
☐ **Sometimes**
☐ **Never**

GPCOG Score or MMSE Score

GPCOG Score	or MMSE Score

If GPCOG or MMSE is not done, is

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

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**

DEPRESSION SCREENING PHQ9

Having little interest or pleasure in doing things?

- ☐ **Not at all**
☐ **Several**
☒ **More than half the days**
- ☐ **Nearly Every Day**

Feeling down, depressed or hopeless at times?

- ☐ Not at all
 ☒ **Several**
☐ More than half the days
- ☐ Nearly Every Day

Do you have trouble falling or staying asleep, sleeping too much?

- ☐ Not at all
 ☒ **Several**
☐ More than half the days
- ☐ Nearly Every Day

Do you feeling tired or having little energy?

- ☒ **Not at all**
☐ Several
 ☐ More than half the days
- ☐ Nearly Every Day

Do you have a poor appetite or overeating?

- ☒ **Not at all**
☐ Several
 ☐ More than half the days
- ☐ Nearly Every Day

Feeling bad about yourself or that you are a failure or have let yourself or your family down?

- ☒ **Not at all**
☐ Several
 ☐ More than half the days
- ☐ Nearly Every Day

Trouble concentrating on things, such as reading the newspaper or watching TV?

- ☒ **Not at all**
☐ Several
 ☐ More than half the days
- ☐ Nearly Every Day

Moving or speaking so slowly that other people have noticed. Or opposite-being fidgety or restless that you have been moving around a lot more than usual?

- ☒ **Not at all**
☐ Several
 ☐ More than half the days
- ☐ Nearly Every Day

Thoughts that you would be better off dead, or hurting yourself?

- ☐ Not at all
 ☒ **Several**
☐ More than half the days
- ☐ Nearly Every Day

comments

JAN 2021 - PYSHC REHAB FOR THE SUICIDAL IDEATION

PHQ 9 Score

8

If Score is Greater than 15, recommend additional treatment

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**

☐ Abductor lurch

☐ Limp

☐ Wide based

☐ Ataxic

☐ Paretic

☐ Shuffling

☐ Other (Findings may also apply to Musculoskeletal diagnoses)

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

☐ Yes

☒ **No**

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

☐ Yes

☒ **No**

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

☐ Yes

☒ **No**

Endocrine Problems

☒ **Yes**

☐ No

Diagnoses

☐ Chronic Kidney Disease secondary to Diabetes

☐ Coronary Artery Disease and Diabetes

☐ Cushing's Disease

☒ **Diabetes**

☐ Diabetic Retinopathy

☐ Secondary Hyperparathyroidism

☐ Hypertension and Diabetes

☐ Hyperthyroidism

☐ Hypothyroidism

☐ Kidney Stone

☐ Peripheral Neuropathy secondary to Diabetes

☐ Peripheral Vascular Disease secondary to Diabetes

☐ Hyperparathyroidism

☐ Other

Diabetes

Describe

☒ **Active**

☐ History of

☐ Rule out

Supported by

☐ Symptoms

☐ Physical findings

☐ Lab tests

☒ **Medications**

☐ Other

Type

☐ Type 1

☒ **Type 2**

☐ Gestational

↳ **Most recent Hb A1C, value**

comments

unknown

↳ **And Date**

comments

unknown

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

☐ Yes

☒ **No**

↳ **Met with a diabetic educator**

☐ Yes

☒ **No**

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

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

☐ C. Difficile

☐ HIV

☐ Hospital Acquired MRSA Infection

☐ Leukemia

☐ Multiple Myeloma

☒ **Anemia**

☐ Community Acquired MRSA Infection

☐ Herpes Zoster

☐ Immune Deficiency

☐ Lymphoma

☐ Sepsis

- ☐ Sickle Cell Disease
- ☐ Thalassemia
- ☐ Tuberculosis
- ☐ Other
- ☐ Sickle Cell Trait
- ☐ Thrombocytopenia
- ☐ Vitamin D Deficiency

comments

IRON DEFICIENCY ANEMIA

Anemia

Describe

- ☐ Active

Supported by

- ☐ Lab tests

- ☒ History of

- ☐ Symptoms

- ☐ Rule out

- ☐ History of blood transfusion

- ☒ Other

Other

Describe

comments

IRON TRANSFUSION PER MEMBER X 1

Etiology

- ☒ Iron deficiency

- ☐ Hemolysis

- ☐ Blood loss

- ☐ Other

- ☐ Pernicious

- ☐ Aplastic

- ☐ Chronic Disease

- ☐ Kidney disease

- ☐ Chemotherapy

- ☐ Folate Deficiency

If yes, Patient on

- ☐ Iron

- ☐ Blood Transfusions

- ☐ B 12

- ☒ Other

- ☐ Folic Acid

Other

Describe

comments

RECEIVED IRON INFESION IN 2020. NOT ON PO AGENT, ASKED TO DISCUSS WITH PCP

Easy bruising or abnormal bleeding

- ☐ Yes

- ☒ No

Long term anticoagulation use

- ☐ Yes

- ☒ No

comments

WAS ON ASPIRIN AND HAD A GI BLEED

Cancer

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

Pain

Does the patient experience pain?

- ☐ Yes

- ☒ No

Vital Signs

Vital Signs

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
126 (mmHG)	80 (mmHG)	67 (bpm)	18	97.8	99	0/10

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	8 (Inch)	166.4 (lbs)	25.3

- ☐ 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 EXTRACTED.

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

Neck

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

Pulmonary

Assessment of respiratory effort:	Normal	Abnormal
Percussion of chest:	Normal	Abnormal
Palpation of chest:	Normal	Abnormal
Auscultation of lungs:	Normal	Abnormal

Cardiovascular

Palpation of heart:	Normal	Abnormal
Auscultation of heart:	Normal	Abnormal
Carotid Arteries:	Normal	Abnormal
Abdominal Aorta:	Normal	Abnormal
Pedal Pulses:	Normal	Abnormal
Examination of Arterial Pulses:	Normal	Abnormal
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
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

II-XII EXCEPT XI

Indicate cranial nerve deficits found

NONE
ABMULATES INDEPENDENTLY, CLIMBS FEW STEPS WITHOUT ANY ASSITANCE

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

Diabetes

Foot Exam:	Normal	Abnormal
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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	Diagnoses	Comments
DIGITAL_RETINAL_EXAM	Yes	Select			Yes		WNL EXAM		
HBA1C	Yes	Left Kit	77000557	77000557	Yes		MAIL IN SPECIMEN	DIABETES MELITUS II	
MICROALBUMIN	Yes	Left Kit	37229220	37229220	Yes		MAIL IN SPECIMEN		
FOBT	Yes	Left Kit	33620346	33620346	Yes	02-21-2021	MAIL IN SPECIMEN		
DEXA	N/A				Select				
PAD	Yes				No				
LDL	Yes	Left Kit	77000557	77000557	Select				

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
Banana

Version 2
Leader

Version 3
Village

Version 4
River

Version 5
Captain

Version 6
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 : 3

Person's Answers: RIVER,NATION,FINGER

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

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 all sleeping a rooms?	Yes	No
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?

GET MY TEETH BACK

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

GET MY TEETH BACK AND EAT BETTER

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 :

MEMBER VERY PLEASANT DISCUSSES RECENT PSYCH REHAB DUE TO SUICIDAL IDEATION. PRIOR TOP PSYCH REHAB, POSITIVE FOR COVID-19 AND REQUIRED HOSPITAL ADMISSION. EDU ON MAIL IN LAB TESTING AND MAIL ALL BAGS WITHIN 24 HOURS.

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 :	2021-02-21T10:56
Time exam finished	2021-02-21T10:57
I accept the Disclosure Statement	<input type="checkbox"/>
Provider Signature	<div> <div>Tejas Vaishnav - TV</div> <div>  <div>Digitally signed by Tejas Vaishnav, NP 2021-03-25, 23:06</div> </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?