

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	BLANCHE E ROBINSON
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1953-02-17
Evaluation Date :	2021-7-8 09:30 AM
Visit Type :	In Person

Demographics

Plan	VPHP - VIRGINIA PREMIER
Program	MEDICARE
LOB	DSNP
Name	BLANCHE E ROBINSON
Gender	Female
Address	1906 IDLEWOOD AVENUE
City	RICHMOND
State	VA
Zip	23220-4461
Date of Birth	1953-02-17
Age(as of date)	68
Marital Status	Single
Member Identification Number	11004915
HICN	6V41NQ1VA33
Phone Number	8049186507
Cell Number	
Alternate Contact Number	
Email	none
Emergency Contact	Ms. Hobson (friend)
Phone Number	804-353-4870
Primary Care Physician	YOUNG, WILLIAM H
Phone Number	8043555550
PCP Address	110 N Robinson St Ste 301
PCP City	Richmond
PCP State	VA

PCP Zip	232204461
PCP County	
Office ID	P0124228
Office Name	WILLIAM H YOUNG MD PC

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

7th grade

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

she only goes to the grocery store with her granddaughter every 2 weeks

9. Where do you currently live?

☐ Home

☒ Apartment

☐ Assisted Living

☐ Nursing Home

☐ Homeless

☐ Other

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

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

Describe

14. Alcohol Use

☐ Current
 ☐ Former
 ☒ **Never**

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

☐ Yes
 ☒ **No**

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

↳ How many stairs can you climb

☐ None
 ☐ Three to five
 ☒ **Six to ten**
☐ More than ten

Medical History

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

☐ None
 ☒ **Cane**
☒ **Walker**
☐ Prosthesis

- ☐ Wheel Chair
 ☐ Bedside Commode
 ☐ Urinal
☐ Bed Pan
 ☐ Other

21. Are you currently seeing any specialists?

- ☐ Yes
 ☒ No

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
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 hospitalization 3 years ago for COPD exacerbation

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
Father	htn, MI, CAD	old age
Mother	Htn, T2DM, envolent on bedrest	alive
Sibling1	CANCER, T2dm, htn	cancer; died in 2020

Preventive Care

27. In the past three years have you had?

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

last colonoscopy June 9, 2021
last breast mammography June 15, 2021
discussed preventative care screenings for cervical screening and bone density (member needs another OBGYN physician, but also educated that she can receive referral from her PCP)

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

☒ Yes

☐ No

☐ NA

comments

Type 2 diabetes

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

↳ Pneumovax

☐ Yes

☐ No

☒ Unknown

↳ Prevenar

☒ Yes

☐ No

☐ Unknown

34. Have you been vaccinated for Herpes Zoster?

☐ Yes

☒ No

comments

discussed preventative care with shingles vaccine
member had covid immunization x2

Allergies / Medications

35. Allergies

☐ Yes

☒ No

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
diabetes	TRUETRACK	TES	SQ = Subcutaneous	QD	young	Taking	Not Taking
yeast	Ketoconazole	2% cream	T = Topical	BID	young	Taking	Not Taking
depression	AMITRIPTYLINE	TAB 25MG	PO = By Mouth	QD	young	Taking	Not Taking
asthma, copd	ALBUTEROL	NEB 0.00083	PO = By Mouth	QID	young	Taking	Not Taking
insomnia, itching	HYDROXYZ HCL	TAB 25MG	PO = By Mouth	HS	young	Taking	Not Taking
copd	SPIRIVA	18mcg	PO = By Mouth	QD	young	Taking	Not Taking
t2dm	METFORMIN	TAB 500MG	PO = By Mouth	BID	young	Taking	Not Taking
gout	ALLOPURINOL	TAB 300MG	PO = By Mouth	QD	young	Taking	Not Taking
asthma	MONTELUKAST	TAB 10MG	PO = By Mouth	QD	young	Taking	Not Taking
htn	VALSART/HCTZ	TAB 160-25MG	PO = By Mouth	QAM	young	Taking	Not Taking
htn	AMLODIPINE	TAB 5MG	PO = By Mouth	QD	young	Taking	Not Taking
hypercholestermia	PRAVASTATIN	TAB 40MG	PO = By Mouth	HS	young	Taking	Not Taking
allergies	loratidine	10mg	PO = By Mouth	QD	young	Taking	Not Taking
gout	COLCHICINE	TAB 0.6MG	PO = By Mouth	QD	young	Taking	Not Taking
asthma	PROAIR HFA	90mcg	PO = By	BID	young	Taking	Not Taking

		aerochamber	Mouth				
pneumonia	AZITHROMY CIN	TAB 250MG	PO = By Mouth	QD	young	Taking	Not Taking
eye itching	CROMOLYN	SOL 4% OP	E = Eye	BID	Dr. Young	Taking	Not Taking
yeast	Nystatin Systemic	100000/ml suspension	PO = By Mouth	TID	young	Taking	Not Taking
anemia	ferrous sulfate	325mg	PO = By Mouth	QD	young	Taking	Not Taking
vitamin d supplementa tion	vitamin d3	2000IU	PO = By Mouth	QD	young	Taking	Not Taking

36. Over the Counter Medications / Supplements

☒ Yes ☐ No

Date	Description	Dose/Units	Route	Frequency
07-08-2021	tylenol	325mg	PO = By Mouth	daily

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

Review of Systems and Diagnoses

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

☒ Yes ☐ No

Diagnoses

☒ Cataracts ☐ Difficulty with vision
☒ Glaucoma ☐ Hyperopia
☐ Macular Degeneration ☐ Myopia
☐ Retinal Disease ☐ Others

Cataracts

Describe

- ☒ **Active**
- ☐ History of
- ☐ Rule out
- ☒ **Supported by**
 - ☒ **History**
 - ☐ Medications
 - ☐ Biopsy
- ☐ Symptoms
- ☐ Test results
- ☐ DME
- ☐ Physical Findings
- ☐ Image studies
- ☐ Other
- ☒ **Secondary to Diabetes**
- ☒ **Yes**
- ☐ No

comments

unknown, but suspected

Glaucoma

Describe

- ☐ Active
- ☐ History of
- ☒ **Rule out**

comments

it is in prior documented conditions list; however, member denies and states that she is on no medications or gtts for glaucoma, unknown, next eye doctor appt is Feb. 2022

Supported by

- ☒ **History**
- ☐ Medications
- ☐ Biopsy
- ☐ Symptoms
- ☐ Test results
- ☐ DME
- ☐ Physical Findings
- ☐ Image studies
- ☐ Other

Secondary to Diabetes

- ☐ Yes
- ☒ **No**

comments

unknown

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

Diagnoses

- ☐ Chronic Post Nasal Drip
- ☐ Sinus Infections
- ☐ Nose Bleeds
- ☒ **Other**

Other

Describe

- ☒ **Active**
- ☐ History of
- ☐ Rule out

Supported by

- ☒ **History**
- ☒ **Medications**
- ☐ Biopsy
- ☐ Symptoms
- ☐ Test results
- ☐ DME
- ☐ Physical Findings
- ☐ Image studies
- ☐ Other

Other

comments

allergic rhinitis

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

☒ Yes

☐ No

Diagnoses

- ☒ Bleeding Gums
- ☐ Difficulty Swallowing
- ☐ Difficulty Chewing
- ☒ Other
- Bleeding Gums

Describe

☒ Active

☐ History of

☐ Rule out
- Other

Describe

☒ Active

☐ History of

☐ Rule out
- Supported by

☒ History

☐ Medications

☐ Biopsy

☐ Symptoms

☐ Test results

☐ DME

☒ Physical Findings

☐ Image studies

☐ Other
- Other

comments

Dx 1: macroglossia 2: oral candidiasis

Neck Problems (parotid Disease, Carotid Stenosis, Other)

☐ Yes

☒ No

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

☒ Yes

☐ No

Diagnoses

- ☐ Acute Pulmonary Embolism
- ☒ Asthma
- ☐ Chronic Respiratory Failure
- ☒ COPD
- ☐ Hypoventilation secondary to Obesity
- ☒ Pneumonia
- ☐ Respirator Dependence/ Tracheostomy Status
- ☐ Sarcoidosis
- ☐ Other
- Acute Upper Respiratory Infection

Chronic Pulmonary Embolism

Chronic Sputum Production

Cystic Fibrosis

Hypoxemia

Pulmonary Fibrosis

Respiratory Arrest

Sleep Apnea
- Asthma

Describe

☒ Active

☐ History of

☐ Rule out
- Supported by

☐ Wheezing

☒ Use of Bronchodilator

☐ Other

☒ Chronic Cough

☒ Use of Inhaled or oral steroids

☐ Cyanosis

☐ Use of ventilator
- Is patient on controller medications

☒ Yes

☐ No
- Does patient use rescue medications

☒ Yes

☐ No

Does patient have current exacerbation

☐ Yes

☒ No

COPD

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Use of accessory muscles

☐ Barrel Chest

☐ XR results

☐ Wheezing

☐ Clubbing

☐ Decreased or prolonged breath sounds

☒ Dyspnea on exertion

☐ O2 use

☐ Brinchodilator medication

☐ Respirator

☐ Other

Has patient been told they have Chronic Bronchitis

☐ Yes

☒ No

Has patient been told they have Emphysema

☒ Yes

☐ No

Is patient on Bronchodilator

☒ Yes

☐ No

Route is

☒ Inhaled

☐ Nebulizer

☐ Oral

Is patient on Steroids

☒ Yes

☐ No

Route is

☒ Inhaled

☐ Nebulizer

☐ Oral

Does patient have current exacerbation

☐ Yes

☒ No

Pneumonia

Describe

☐ Active

☒ History of

☐ Rule Out

Supported by

☐ Hospitalization

☒ Physical findings

☐ Image studies

☐ Lab studies

☐ Other

Etiology

☒ Viral

☐ Pneumococcal

☐ Staph

☐ Other Bacterial

☐ Aspiration

comments

last took azithromycin May 2021

History / finding of Lung abscess

☐ Yes

☒ No

History / finding of Empyema

☐ Yes

☒ No

Use of Oxygen

☐ Yes

☒ No

Shortness of breath

☒ Yes

☐ No

Wheezing

☒ Yes

☐ No

Chronic Cough

☒ Yes

☐ No

Patient requires durable medical equipment

☐ Yes

☒ No

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

☒ Yes

☐ No

Diagnoses

- ☐ Abnormal Cardiac Rhythm

☐ Angina

☐ Cardio – Respiratory Failure / Shock

☐ Congestive Heart Failure

☒ Hyperlipidemia

☐ Ischemic Heart Disease (CAD)

☐ Peripheral Vascular Disease

☐ Valvular Disease
- ☐ Aneurysm

☐ Atrial Fibrillation

☐ Cardiomyopathy

☐ Deep Vein Thrombosis

☒ Hypertension

☐ Myocardial Infarction

☐ Pulmonary Hypertension

☐ Other

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

Adequately controlled

☒ Yes

☐ No

☐ UnKnown

History of Chest Pain

☒ Yes

☐ No

Pain described as

☐ Achy

☐ Sharp

☒ Tight

☐ Crushing

comments

"tightness when I'm short of breath"

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
 ☐ Stress / Anxiety
 ☐ Other

↳ Is pain relieved by oral medication

☒ **Yes**
☐ No

comments

relieved by nebulizer treatment

↳ How long before pain is relieved

☐ 1min
 ☐ 2min
 ☐ 5min

☒ **>5min**

↳ What medication / s

albuterol nebulizer, proair, spiriva

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**

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

- ☐ 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

Insomnia

Describe

☒ Active

☐ History Of

☐ Rule out

Supported by

☒ Medication

☐ Symptoms

☐ History

☐ Other

Intellectual and or Developmental Disability

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ History

☐ Medications

☐ Test results

☐ Physical Findings

☐ Biopsy

☐ DME

☐ Image studies

☐ Other

Describe

☐ Down's Syndrome

☐ Psychomotor Retardation

☒ Other

Other

Describe

comments

illiterate; inability to read and write

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

comments

twice a month goes grocery shopping with family

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**

comments

mainly related to her breathing and when walking up and down her stairs

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

PHQ 9 Score

12

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)

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Intention Tremor | <input type="checkbox"/> Non-Intention (Pill rolling) Tremor | <input type="checkbox"/> Rigidity |
| <input type="checkbox"/> Spasticity | <input type="checkbox"/> Chorea Movement | <input type="checkbox"/> Cog wheeling |
| <input checked="" type="checkbox"/> Normal | | |

Gait

- | | | |
|---|---|-------------------------------------|
| <input checked="" type="checkbox"/> Normal | <input type="checkbox"/> Limp | <input type="checkbox"/> Wide based |
| <input type="checkbox"/> Abductor lurch | <input type="checkbox"/> Paretic | <input type="checkbox"/> Shuffling |
| <input type="checkbox"/> Ataxic | <input type="checkbox"/> Other (Findings may also apply to Musculoskeletal diagnoses) | |

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

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|---|

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

- | | |
|--|-----------------------------|
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
|--|-----------------------------|

Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Collagen (Connective) Tissue Disease | <input type="checkbox"/> Degenerative Disc Disease |
| <input type="checkbox"/> Extremity Fracture (other than Hip) | <input checked="" 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 type="checkbox"/> Other |

Gout

Describe

- | | | |
|---|-------------------------------------|-----------------------------------|
| <input checked="" type="checkbox"/> Active | <input type="checkbox"/> History of | <input type="checkbox"/> Rule out |
|---|-------------------------------------|-----------------------------------|

Supported by

- | | | |
|---|------------------------------------|--|
| <input checked="" type="checkbox"/> History of attacks in Foot | <input type="checkbox"/> Lab tests | <input checked="" type="checkbox"/> Medications |
| <input type="checkbox"/> Other | | |

History / Finding of non- extremity Fracture

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|---|

History / Finding of Hip Fracture / Dislocation

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|---|

History / Finding of Vertebral Fracture

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|---|

Do you have any swelling of your joints?

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|---|

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

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|---|

Do you have pain in your joints?

- | | |
|------------------------------|---|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> 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

↳ Diagnoses

☐ Basil Cell Carcinoma
☐ Eczema
☐ Skin ulcer
☐ Wound

☐ Dermatitis
☐ Psoriasis
☐ Urticarial Disease
☒ Other

Other

↳ Describe

☒ Active

☐ History of

☐ Rule out

↳ Supported by

☒ History

☒ Symptoms

☒ Physical Findings

☒ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

↳ Other

comments

candiasis of skin (vaginal area), oral candiasis

Do you have ulcers or wounds that require dressings?

☐ Yes ☒ No

Do you have a chronic skin condition?

☒ Yes ☐ No

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

☒ Yes ☐ No

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

☐ Yes ☒ No

Do you have skin breakdown or ulcers around your ankles?

☐ 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

☐ Peripheral Vascular Disease

- to Diabetes
- ☐ Hyperparathyroidism
- ☐ secondary to Diabetes
- ☐ 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 April 2021

- Met with a nurse or dietician for diabetic education
 - ☐ Yes
 - ☒ No
- Met with a diabetic educator
 - ☐ Yes
 - ☒ No

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

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

- ☐ Yes
- ☒ No

Do you often feel thirsty?

- ☒ Yes
- ☐ No

comments states she is drinking water all the time

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

comments right foot has pain and itching at night

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

comments

right foot at night

Do you test your blood sugar?

☒ Yes

☐ No

comments

once 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

☐ C. Difficile

☐ HIV

☐ Hospital Acquired MRSA Infection

☐ Leukemia

☐ Multiple Myeloma

☐ Sickle Cell Disease

☐ Thalassemia

☐ Tuberculosis

☐ Other
- ☒ Anemia

☐ Community Acquired MRSA Infection

☐ Herpes Zoster

☐ Immune Deficiency

☐ Lymphoma

☐ Sepsis

☐ Sickle Cell Trait

☐ Thrombocytopenia

☒ Vitamin D Deficiency

Anemia

Describe

- ☒ Active

☐ History of

☐ Rule out

Supported by

- ☐ Lab tests

☒ Symptoms

☐ History of blood transfusion

Other

Other

Describe

comments

medication

Etiology

- ☒ Iron deficiency

☐ Hemolysis

☐ Blood loss

☐ Other

☐ Pernicious

☐ Aplastic

☐ Chronic Disease

☐ Kidney disease

☐ Chemotherapy

☐ Folate Deficiency

If yes, Patient on

- ☒ Iron

☐ B 12

☐ Folic Acid

☐ Blood Transfusions

☐ Other

Vitamin D Deficiency

Describe

- ☒ **Active**
- ☐ History of
- ☐ Rule out
- ☒ **Supported by**
 - ☐ Labs
 - ☐ Other
- ☒ **Medications**
- ☐ History

Easy bruising or abnormal bleeding

☒ **Yes** ☐ No

Long term anticoagulation use

☐ Yes ☒ **No**

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**

right foot, member states sometimes her right side hurts her.

- ☒ **Do you take Methadone**
 - ☐ Yes
 - ☒ **No**

- ☒ **What drug/s do you take for it**

tylenol

- ☒ **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**

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

comments

Member elevated pulse, RR and low PaO2 was discussed at time of exam. Member had walked from her bathroom back to her chair with increased RR and pulse

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
121 (mmHG)	89 (mmHG)	100 (bpm)	24	97.6	93	0

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	1 (Inch)	195 (lbs)	36.8

- ☐ 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: no teeth in the back of mouth

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

Comment: deferred

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

Comment: expiratory wheezing b/l lower bases

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; obese

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
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
---	--------	----------

Comment:

nevi left side of face; oral thrush

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:

deferre

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

Diabetes

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

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	Diagnosi s	Commen ts
DIGITAL_	No	Completed			Yes	07-08-2021	images	Type 2	

RETINAL_EXAM		Kit with Member					too dark for submission ; provided educated for follow-up to have eyes dilatated	diabetes mellitus	
HBA1C	No	Completed Kit with Member	77000611	77000611	Yes	07-08-2021		Type 2 diabetes mellitus; diabetic retinopath y	completed with member
MICROALBUMIN	No	Completed Kit with Member	37239597	37239597	Yes	07-08-2021		Type 2 diabetes mellitus with unspecifie d diabetic retinopath y without macular edema	completed with member
FOBT	Yes	Refused Kit			Member Refused				
DEXA	No	Select			Select				
PAD	No	Completed Kit with Member			Yes	07-08-2021	Lt foot=1.01 Rt foot=0.98	Type 2 diabetes mellitus; Normal testing PAD	
LDL	N/A	Select			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	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

Word Recall :	2 Points	1 point for each word spontaneously recalled without cueing. Home Safety Yes
Clock Draw :	0 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 :	2 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?

"I could read" and "I wish my breathing was better"

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

"I wish I could do more cleaning in my house - keeping it clean and scrubbing, but I can't breathe."

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 :

68yo female lives in apartment/townhome setting with a friend that comes in and out at times. She cannot read anything, will go to her emergency contact home when filling out medical information to help assist her with reading and writing. She score low on mini-cog, but I do not suspect dementia as she is illiterate and has difficulties with reading and writing. She is fluent in language and understands/speaks appropriately when answering questions. She has polypharmacy and sometimes forgets to take her medications. She does not have a HHA that comes in, but this member would greatly benefit assistance with medication compliance, household chores, and bathing. She has difficulty bathing now because she becomes increasingly SOB from her asthma and COPD. Member is pleasant and agrees to discuss services that would benefit her. Member wants information on podiatrist in her area. Additionally, member needs preventative care cervical screening and bone density. Member wants information on a OBGYN; however, educated that she can also received referrals for these services from her PCP. She currently only sees Dr. William Young, her PCP. CM referral completed.

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 :	2021-07-08T09:57
Time exam finished	2021-07-08T11:06
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Provider Signature	<div><div>Digitally signed by Brittney Walls, FNP 2021-07-21, 14:11</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?