

HRA Form

Plan :	VPHP - VIRGINIA PREMIER
Program :	Medicare
LOB :	DSNP
Region :	ROANOKE/ALLEGHANY
Aligned :	Y
Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	YVETTE W SEAMSTER
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1967-08-22
Evaluation Date :	
Visit Type :	

Demographics

Name	YVETTE W SEAMSTER
Gender	Female
Address	1062 PEPPERTREE ROAD
City	BEDFORD
State	VA
Zip	245236736
Date of Birth	1967-08-22
Age(as of date)	53
Marital Status	
Member Identification Number	11006874
HICN	3Y59QC0NK22
Phone Number	5405860609
Cell Number	
Email	
Emergency Contact	
Phone Number	
Primary Care Physician	KURIAN, WILBY
Phone Number	4347912612
PCP Address	404 Airport Dr Ste A
PCP City	Danville

PCP State	VA
PCP Zip	245405196
PCP County	
Office ID	P9338917
Office Name	CENTRA MEDICAL GROUP

Covid Screening

In the last 14 days, have you:

Traveled internationally?

Answer:

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

Answer:

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

Answer:

Developed Fever?

Answer:

Developed Cough?

Answer:

Developed Flu like symptoms?

Answer:

Developed Shortness of breath?

Answer:

Self-Assessment and Social History

13. Tobacco use

14. Alcohol Use

Answer:

Activities of Daily Living

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

A. Getting in or out of bed

Answer:

B. Getting in or out of chairs

Answer:

C. Toileting

Answer:

D. Bathing

Answer:

E. Dressing

Answer:

F. Eating

Answer:

G. Walking

Answer:

H. Going up or down stairs

Answer:

Medical History

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

Answer:

21. Are you currently seeing any specialists?

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

A. Seen your PCP

Answer:

B. Visited the Emergency Room

Answer:

C. Stayed in the hospital overnight

Answer:

D. Been in a nursing home

Answer:

E. Had Surgery

Answer:

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

Physical Therapist

Answer:

Occupational Therapist

Answer:

Dietician

Answer:

Social Worker

Answer:

Pharmacist

Answer:

Speech Therapist

Answer:

Chiropractor

Answer:

Personal Care Worker (HHA, CNA, PCA)

Answer:

Meals on Wheels

Answer:

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

Chemotherapy

Answer:

Catheter Care

Answer:

Oxygen

Answer:

Wound Care

Answer:

Regular Injections

Answer:

Tube Feedings

Answer:

Family History

26. Family History

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	
Breast Exam/Mammography	
Cervical Screening	
Bone Density	

Prostate Exam/PSA	
If Diabetic Eye Exam	
If Diabetic Foot Exam	
If Diabetic Hgb A1c screen	
Lipid Panel	

Allergies / Medications

35. Allergies

Answer:

Medications

Dose Date	Label Name	Dose / Units	Route	Frequency	Status
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36. Over the Counter Medications / Supplements

Answer:

37. Chronic Use of

Answer:

38. Medication Compliance and Knowledge of Use and Disease

1. Do you ever forget to take your medicine?

Answer:

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

Answer:

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

Answer:

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

Answer:

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

Answer:

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


Answer:

Review of Systems and Diagnoses

EYES

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

Answer:

 FOCUSCARE

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EARS

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

Answer:

NOSE

Nose Problems (Nose Bleeds, Sinus infections, Other)

Answer:

MOUTH AND THROAT

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

Answer:

NECK

Neck Problems (parotid Disease, Carotid Stenosis, Other)

Answer:

RESPIRATORY

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

Answer:

CARDIOVASCULAR

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

Answer:

GASTROINTESTINAL

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

Answer:

NEURO-PSYCH

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

Answer:

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

GPCOG Score or MMSE Score

GPCOG Score

or MMSE Score

GENITOURINARY

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

Answer:

MUSCULOSKELETAL

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

Answer:

INTEGUMENT

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

Answer:

ENDOCRINE

Endocrine Problems

Answer:

HEMATOLOGY / IMMUNOLOGY / INFECTIOUS DISEASE

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

Answer:

Pain

Vital Signs

Vital Signs

Blood Pressure	
Pulse	
Respiratory Rate	
Temp	
Pulse Oximetry	
Pain Scale /10	

BMI

Comment:

Patients Height	
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Patients Weight	
BMI	

Exam Review

Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnosis	Comments
DIGITAL_RETINAL_EXAM	No	Select			Select				
HBA1C	No	Select			Select				
MICROALBUMIN	No	Select			Select				
FOBT	Yes	Select			Select				
DEXA	N/A	Select			Select				
PAD	No	Select			Select				
LDL	No	Select			Select				

Mini-Cog	
Word List Version	
Person's Answers	
Word Recall	
Clock Draw	
Total Score	

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:*

b. Do you have electrical cords running across floors, in doorways or under a rugs?  
*Answer:*

c. Do you have no slip mats on the shower floor or bath tub?  
*Answer:*

d. Do have adequate lighting in hallways and on the stairs?  
*Answer:*

e. Do you have handrails on staircases?  
*Answer:*

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

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

h. Do you have carbon Monoxide detectors on each level of the house?  
*Answer:*

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

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

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

Patient Summary	
Assessors Comments	
Member informed of acknowledgment	
Date/Time of Service/ Evaluation :	
Time exam finished	
Provider Signature	
Addendum	<div></div>
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

	<p>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</p>
Disclosure Statement	<div><div>Your health plan has asked Focus Care to conduct, on its behalf, health assessments on its patients. The health assessment includes questions to help your health plan learn more about your current health status, including potential health risks. This information will help your health plan and your physician help you maintain or achieve your best state of health.</div><div>Generally, your personal health information (PHI) may only be used and disclosed by us with your express written authorization. Focus Care has implemented several security measures to protect your PHI from being released orally, in writing, or electronically. Additional information about these safeguards are available upon request.</div><div>Treatment Purposes. We may disclose medical information about you to other health care providers who are or will be involved in taking care of you. For example, the results of your health assessment will be sent to your health plan. Your health plan will use this information to identify your health needs and offer available programs to you. Your health plan shares your completed health risk assessment with your physician.</div><div>Payment Purposes. We may use or disclose your medical information for payment purposes. It is necessary for us to disclose your completed health assessment to your health plan so that we may bill and receive payment for this service.</div><div>Health Care Operations. We may use and disclose your personal health information in order for us to conduct our healthcare business, which is administration of the health assessment on behalf of your health plan.</div><div>Other uses and disclosures of your PHI will be made only with your written authorization unless otherwise permitted or required by law. The use or disclosure will be made in compliance with the law and will be limited to the requirements of such law.</div><div>In addition, we may release your personal health information to third party 'business associates' who perform various activities for us, such as billing or electronic transmissions of PHI. Whenever our arrangement with a business associate involves the use</div></div>

	or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.
	Your agreement to participate with the health assessment implies your consent to provide the results of your health assessment to your health plan.