

HRA Form

Plan :	VPHP - VIRGINIA PREMIER
Program :	Medicare
LOB :	DSNP
Region :	CENTRAL
Aligned :	Y
Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	ZAIBUNNISA B JAFFER
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1950-03-27
Evaluation Date :	
Visit Type :	

Demographics	
Name	ZAIBUNNISA B JAFFER
Gender	Female
Address	9301 ELECTRA LN
City	HENRICO
State	VA
Zip	232289999
Date of Birth	1950-03-27
Age(as of date)	71
Marital Status	Married
Member Identification Number	11007001
HICN	6HD2PM4FU16
Phone Number	8047281633
Cell Number	
Email	
Emergency Contact	husband
Phone Number	804-262-2444
Primary Care Physician	DOMAH, NAU
Phone Number	8042262444
PCP Address	5855 Bremo Rd
PCP City	Richmond

PCP State	VA
PCP Zip	232261930
PCP County	
Office ID	P0060041
Office Name	PRIMARY HEALTH CARE ASSOCIATES

1. Race

Answer: Other

Describe

Answer: ASIAN/PACIFIC

Patient's Ethnicity

Answer:

2. Preferred language

Answer:

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

3. How much school have you completed?

Answer: Attended College

4. When you get written information at a doctor's office would you say it is <i>Answer: Easy</i>
5. When you read the instructions on a prescription bottle would you say that it is <i>Answer: Easy</i>
6. How confident are you in filling out medical forms by yourself? <i>Answer: Confident</i>
7. How would you rate your health compared to other persons your age? <i>Answer: Good</i>
8. During past 3 months, has your physical and or emotional health limited your social activities with family, friends, neighbours or groups? <i>Answer: Sometimes</i>
9. Where do you currently live? <i>Answer: Home</i>
10. Do you have someone you can rely on to help if you are sick or have problems you need to discuss? <i>Answer: Yes</i>
11. Who do you currently live with? <i>Answer: Spouse</i>
12. Are you currently a caregiver for someone? <i>Answer: No</i>
13. Tobacco use <i>Answer: Never</i>
14. Alcohol Use <i>Answer: Never</i>
15. Do you or have you used recreational drugs or pain medication? <i>Answer: No</i>
16. Do you have a Healthcare Proxy? <i>Answer: No</i>
17. Do you have a Durable Power of Attorney? <i>Answer: No</i>
18. Do you have an Advance Directive? <i>Answer: No</i>
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?

Answer: 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?
Answer: Never True

Activities of Daily Living

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

A. Getting in or out of bed
Answer: Need Some Help

B. Getting in or out of chairs
Answer: Need Some Help

C. Toileting
Answer: No

D. Bathing
Answer: No

E. Dressing
Answer: No

F. Eating
Answer: No

G. Walking
Answer: Need Some Help
How far can you walk
Answer: Less than one block

H. Going up or down stairs
Answer: Need Some Help
How many stairs can you climb
Answer: Three to five

Medical History

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

21. Are you currently seeing any specialists?
Answer: Yes

Medical Specialty	Specialist	For
Hematologist	Dr. Kumar Abhishek	low platelets
Other	Dr. Dumah	knees, ankles, joints in hands

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

A. Seen your PCP
Answer: 4

B. Visited the Emergency Room
Answer: 1

If one or more, describe
Answer: low platelets and bleeding

C. Stayed in the hospital overnight
Answer: 3

If one or more, describe
Answer: same as above

D. Been in a nursing home
Answer: None

E. Had Surgery
Answer: None

23. Have you ever been hospitalized prior to the last 12 months?
Answer: No

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

Physical Therapist
Answer: Yes

Occupational Therapist
Answer: No

Dietician
Answer: No

Social Worker
Answer: No

Pharmacist
Answer: No

Speech Therapist

Answer: No

Chiropractor

Answer: No

Personal Care Worker (HHA, CNA, PCA)

Answer: Yes

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: No

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	cancer throat	
Mother	passed 1994	

Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	No
Breast Exam/Mammography	No
Cervical Screening	No

Bone Density	No
Prostate Exam/PSA	Not Applicable
If Diabetic Eye Exam	Not Applicable
If Diabetic Foot Exam	Not Applicable
If Diabetic Hgb A1c screen	Yes
Lipid Panel	Yes

28. Last colonoscopy if more than 2 years ago
Answer: > 10 years ago

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

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

31. One time screen for Hepatitis C if born between 1945 - 1965
Answer: No

32. Do you get Flu Vaccine each year?
Answer: Yes

33. Have you been vaccinated for Pneumonia?
Answer: Yes
Pneumovax
Answer: Yes
Prevenar
Answer: Yes

34. Have you been vaccinated for Herpes Zoster?
Answer: No

Allergies / Medications

35. Allergies
Answer: No

Medications

Dose Date	Label Name	Dose / Units	Route	Frequency	Status
2021-04-27	promacta	25 mg/1 tablet	PO = By Mouth	QD	Taking

36. Over the Counter Medications / Supplements
Answer: yes

Date	Description	Dose/Units	Route	Frequency
2021-04-27	multivitamin	1 tablet	PO = By Mouth	q day
2021-04-27	Vitamin D	1 tablet	PO = By Mouth	q day

37. Chronic Use of

Answer: None
Comment:

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: Yes
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: Yes

Review of Systems and Diagnoses

EYES

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

Answer: Yes

Diagnoses

Cataracts

Describe

Answer: Active

Supported by

Answer: History, Symptoms

Comment: had cataract surgery right eye partially blind

Secondary to Diabetes

Answer: No

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 : Yes

Do you have problems seeing at night?

Answer: Yes

Do you have eye pain?

Answer: No

Do you have problems with tearing?

Answer: No

Do you have a problem with dry eye?

Answer: No

EARS

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

Answer: Yes

Diagnoses

Difficulty with Hearing

Describe

Answer: Active

Comment: middle ear surgery, removed stapes right ear

Do you have trouble hearing when people talk to you?

Answer: Yes

Do you wear a hearing aid?

Answer: Yes

How often do you wear it

Answer : Occasionally

Comment: "I do not usually wear hearing aid"

Do you still have trouble hearing with it?

Answer : Yes

Do you read lips?

Answer: No

Do you have ear pain or drainage?

<div>Answer: No</div> <div>Do you ever get dizzy?</div> <div>Answer: No</div>
<div>NOSE</div> <div>Nose Problems (Nose Bleeds, Sinus infections, Other)</div> <div>Answer: Yes</div> <div>Diagnoses</div> <div>Chronic Post Nasal Drip</div> <div>Describe</div> <div>Answer: Active</div> <div>Supported by</div> <div>Answer: Symptoms</div> <div>Comment: related to seasonal allergies</div>
<div>MOUTH AND THROAT</div> <div>Mouth and Throat Problems (Difficulty Chewing, Difficulty Swallowing, Bleeding Gums, Other)</div> <div>Answer: No</div>
<div>NECK</div> <div>Neck Problems (parotid Disease, Carotid Stenosis, Other)</div> <div>Answer: No</div>
<div>RESPIRATORY</div> <div>Respiratory Problems (COPD, Emphysema, Asthma, Chronic Bronchitis Pneumonia, Other)</div> <div>Answer: No</div>
<div>CARDIOVASCULAR</div> <div>Cardiovascular (Hypertension, Angina, Ischemic Heart Disease(CAD), Myocardial Infarction, Other)</div> <div>Answer: No</div>
<div>GASTROINTESTINAL</div> <div>Gastrointestinal Problems (Ulcer, Reflux, Hiatal Hernia, Colitis, Other)</div> <div>Answer: No</div>
<div>Bowel Movements</div>

Answer: Normal	
Abdominal Openings	
Answer: No	
Rectal Problems	
Answer: No	
Last Bowel Movement	
Answer: Today	
NEURO-PSYCH	
Neuro / Psych Problems (Stroke, Parkinson's disease, Seizures Paraplegia, Depression, Other)	
Answer: No	
Neuro / Psych Problems (Stroke, Parkinson's disease, Seizures Paraplegia, Depression, Other)	
Are you nervous, anxious, feel on the edge or often feel stressed?	
Answer: No	
Do you worry too much about different things?	
Answer: No	
Do you feel afraid that something bad might happen?	
Answer: No	
How often do you go out to meet with family or friends	
Answer: Often	
GPCOG Score or MMSE Score	
GPCOG Score	
or MMSE Score	
If GPCOG or MMSE is not done, is	
Patient oriented to person	
Answer: Yes	
Patient oriented to place	
Answer: Yes	
Patient oriented to time	
Answer: Yes	
Recall	
Answer: Good	
Patient describes recent news event	
Answer: Yes	

Affect <i>Answer: Normal</i>
Over the past 2 weeks, how often have you been bothered by any of the following problems? Little interest or pleasure in doing things <i>Answer: Not at all</i> Feeling down, depressed or hopeless <i>Answer: Not at all</i> PHQ 2 Score : <3
Speech <i>Answer: Normal</i>
Finger to Nose <i>Answer: Normal</i>
Heel (Shin) to Toe <i>Answer: Normal</i>
Thumb to Finger Tips <i>Answer: Normal</i>
Sitting to Standing <i>Answer: Normal</i>
Facial / Extremity Movement <i>Answer: Normal</i>
Gait <i>Answer: Normal</i>
GENITOURINARY Genitourinary Problems (Overactive Bladder, Urinary Incontinence Stress Incontinence, Benign Prostatic Hypertrophy, Others) <i>Answer: Yes</i> Diagnoses Urinary Incontinence Describe <i>Answer: Active</i> Supported by <i>Answer: History, Symptoms</i>

Related to stress

Answer: Yes

Related to

Answer: Urgency

Describe

Answer: Daily

History of frequency

Answer: No

History of Nocturia

Answer: Yes

Answer : 1x / night

History of Hesitancy

Answer: No

Do you have trouble urinating?

Answer: No

Do you ever have blood in your urine?

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 holding your urine?

Answer: Yes

Do you trouble getting to the bathroom on time?

Answer: Yes

Comment: sometimes

Do you ever have pain or burning during urination?

Answer: No

Do you ever wear pads or diapers?
Answer: Yes

Do you have a vaginal discharge?
Answer: No

Do you have vaginal bleeding?
Answer: No

MUSCULOSKELETAL

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

Answer: Yes

Diagnoses

Osteoarthritis

Describe

Answer: Active

Supported by

Answer: Symptoms, Physical Findings

Which joints

Answer: both knees, PIP, MCP, DIP

Osteoporosis

Describe

Answer: Active

Supported by

Answer: Symptoms

Comment: cervical kyphosis

Rheumatoid Arthritis

Describe

Answer: Active

Supported by

Answer: Symptoms, Physical findings

Which joints

Answer: bilateral knees, wrist arthritis and hand pain

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: Yes

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

Answer: Yes

Do you have pain in your joints?

Answer: Yes

Do you have a problem straightening any joints?

Answer: Yes

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

Answer: Yes

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

Answer: No

Do you have constant pain in your bones?

Answer: Yes

Have you had an amputation?

Answer: No

INTEGUMENT

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

Answer: No

ENDOCRINE

Endocrine Problems

Answer: No

Have you lost weight in the past 6 months?

Answer: None

HEMATOLOGY / IMMUNOLOGY / INFECTIOUS DISEASE

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

Answer: Yes

Diagnoses

Thrombocytopenia

Describe

Answer: Active

Supported by

Answer: Lab tests, Physical findings, Other

Other

Describe

Answer: areas of bruising,recent hospitalization, seeing hematologist

Etiology

Answer: she takes Promacta

Vitamin D Deficiency

Describe

Answer: Active

Supported by

Answer: Medications

Easy bruising or abnormal bleeding

Answer: Yes

Long term anticoagulation use

Answer: No

CANCER

Diagnosis of Cancer

Answer: No

Pain

Does the patient experience pain?

Answer: Yes

Is the Pain Acute?

Answer: No

Is the Pain Chronic?

Answer: Yes

Describe

Answer: Active

Where

Answer: knees, bilateral wrist, ankles, knees

Do you take Methadone

Answer: No

What drug/s do you take for it

Answer: "I do not take anything due to thrombocytopenia"

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

Answer: 9/10 at max

Is the Patient Undergoing Pain Management Planning?

Answer: No

Was the patient advised regarding the potential for dependence?

Answer: No

Is there any evidence of Maladaptive Behavior?

Tolerance?

Answer: No

Withdrawal?

Answer: No

Increased usage over a longer period that intended?

Answer: No

Desire or unsuccessful effort to cut down on use?

Answer: No

Excess time spent in activities to obtain the substance?

Answer: No

Continued use despite Doctor advice or patient knowledge of habituation?

Answer: No

Physical or Psychological Problem related to the substance use?

Answer: No

Vital Signs

Vital Signs

Blood Pressure	108/80 mmHG
Pulse	83 bpm
Respiratory Rate	14
Temp	97.4
Pulse Oximetry	95

Pain Scale /10	9/10
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BMI
Comment:

Patients Height	4 feet 11 inch
Patients Weight	114 lbs
BMI	23.0

Exam Review

Constitutional
General appearance:
Answer: Normal

Head and Face
Examination of head and face:
Answer: Normal
Palpation of the face and sinuses:
Answer: Normal

Eyes
Inspection of conjunctiva and lids:
Answer: Normal
Examination of pupils and irises:
Answer: Normal

Ears, Nose, Mouth and Throat
External Inspection of ears and nose:
Answer: Normal
Otoscopic examination:
Answer: Abnormal
Comment: stapes not visualized
Assessment of hearing:
Answer: Normal
Inspection of nasal mucosa, septum and trubينات:
Answer: Normal

Inspection of lips, teeth and gums: <i>Answer: Normal</i>
Examination of oropharynx: <i>Answer: Normal</i>

Neck
Examination of neck: <i>Answer: Normal</i>
Examination of thyroid: <i>Answer: Normal</i>

Pulmonary
Assessment of respiratory effort: <i>Answer: Normal</i>
Percussion of chest: <i>Answer: Normal</i>
Palpation of chest: <i>Answer: Normal</i>
Auscultation of lungs: <i>Answer: Normal</i>

Cardiovascular
Palpation of heart: <i>Answer: Normal</i>
Auscultation of heart: <i>Answer: Normal</i>
Carotid Arteries: <i>Answer: Normal</i>
Abdominal Aorta: <i>Answer: Normal</i>
Pedal Pulses: <i>Answer: Normal</i>
Examination of Arterial Pulses: <i>Answer: Normal</i>

Examination of Edema / Varicosities: <i>Answer: Normal</i>
Lymphatic
Palpation of cervical nodes (neck) <i>Answer: Normal</i>
Palpation of preauricular nodes (in front of the ears) <i>Answer: Normal</i>
Palpation of Submandibular nodes (under jaw line/chin) <i>Answer: Normal</i>
Musculoskeletal
Examination of gait and station: <i>Answer: Normal</i>
Inspection/palpation of digits and nails: <i>Answer: Abnormal</i> <i>Comment: slightly deformed PIP and DIP joints</i>
Inspection/palpation of joints, bones and muscles: <i>Answer: Normal</i>
Assessment of range of motion: <i>Answer: Normal</i>
Assessment of stability: <i>Answer: Normal</i>
Assessment of muscle strength/tone: <i>Answer: Normal</i>
Skin
Inspection of skin and subcutaneous tissue: <i>Answer: Normal</i>
Palpation of skin and subcutaneous tissue: <i>Answer: Normal</i>
Neurologic
Indicate specific cranial nerve tested

Answer: II, III, V, VI, X, XI
Indicate cranial nerve deficits found Answer: normal
Romberg Test Answer: Normal
Examination of reflexes: Answer: Normal
Examination of sensation: Answer: Normal
Coordination: Answer: Normal

Diabetes
Foot Exam: Answer: Comment: deferred

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

Screenings Needed									
Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnosis	Comments
DIGITAL_RE TINAL	No	Select			Select				

_EXAM									
HBA1C	No	Select			Select				
MICROALBUMIN	No	Select			Select				
FOBT	Yes	Left Kit	33716265	33716265	Select			Z12.11	
DEXA	Select	Select			Select				
PAD	No	Select			Select				
LDL	No	Select			Select				

Mini-Cog

Word List Version	1
Person's Answers	banana, sunrise, chair
Word Recall	3
Clock Draw	2
Total Score	5

Home Safety & Personal Goals

40. In the past year how many times have you Fallen?
Answer: None

41. Home Safety

a. Do you have obstacles in the house, loose small rugs or objects on the floor that could cause tripping?
Answer: Yes

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

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: No

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: I am doing pretty good


43. Is there anything that you could do to improve your quality of life?
Answer: No, I am fine

44. Have you ever physically or felt emotionally abused by someone
Answer: No

45. Feeling like harming others or yourself
Answer: No

46. Are you afraid of anyone or is anyone hurting you?
Answer: No

Patient Summary

Assessors Comments	Needs dexascan has kyphosis cervical, has not been screened for osteoporosis, needs dexa scan
Member informed of acknowledgment	true
Date/Time of Service/ Evaluation :	
Time exam finished	
Provider Signature	<div><div>Greta Bakanowski</div><div>Digitally signed by Greta Bakanowski, FNP 2021-05-03, 11:20</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

	<p>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</p>
Disclosure Statement	<div><div><p>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.</p></div><div><p>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.</p></div><div><p>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.</p></div><div><p>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.</p></div><div><p>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.</p></div><div><p>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.</p></div><div><p>In addition, we may release your personal health information to third party 'business associates' who</p></div></div>

	perform various activities for us, such as billing or electronic transmissions of PHI. Whenever our arrangement with a business associate involves the use 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.