

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	ALLENZA COLES
Evaluator Name :	Lindsay Otis, NP
Assessment Type :	Health Risk Assessment
DOB :	1931-06-03
Evaluation Date :	2021-7-17 11:00 AM
Visit Type :	Virtual: Video & Audio Capability

Demographics

Plan	VPHP - VIRGINIA PREMIER
Program	MEDICARE
LOB	DSNP
Name	ALLENZA COLES
Gender	Male
Address	PO BOX 33
City	HURT
State	VA
Zip	24563-2023
Date of Birth	1931-06-03
Age(as of date)	90
Marital Status	Widowed
Member Identification Number	11007724
HICN	2QN0MF2DG44
Phone Number	4349442556
Cell Number	4343696970
Alternate Contact Number	
Email	
Emergency Contact	Doris Coles- daughter
Phone Number	4349443937
Primary Care Physician	ELLIOTT, ROBERT
Phone Number	4343528235
PCP Address	527 Pocket Rd
PCP City	Hurt
PCP State	VA

PCP Zip	245632023
PCP County	
Office ID	P9307474
Office Name	PRIVIA MEDICAL GROUP LLC

1. Race

- ☐ Caucasian
 ☒ **African American**
☐ Asian
- ☐ Latino
 ☐ Native American
 ☐ Native Hawaiian or other Pacific Islander
- ☐ Alaskan Native
 ☐ Other

Patient's Ethnicity

- ☐ Hispanic
 ☒ **Non-Hispanic**
☐ Other Ethnicity
- ☐ Prefer not to say

2. Preferred language

- ☒ **English**
☐ 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?

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

comments

through 6th 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

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

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

↳ Name

Helen Tubbs

↳ Relationship

daughter

18. Do you have an Advance Directive?

☒ **Yes**
☐ No
 ☐ Don't Know

↳ Where is it kept?

with family

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

↳ How far can you walk

☒ **Household only**
☐ Less than one block
 ☐ One block
☐ Two or more blocks
 ☐ Non-ambulatory

Comments: using a wheelchair most of the time, is able to make transfers

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

Medical Specialty	Specialist	For
Cardiologist		HTN, CHF
Urologist		chronic UTI, BPH
Podiatrist		foot ulcer, DM foot checks
Gastroenterologist		GERD, diverticulosis

comments daughter did not have the Dr. names available

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

A. Seen your PCP	None	1	2	3	4	5 or more
------------------	------	---	---	---	---	-----------

Comment: has an appt early next week

B. Visited the Emergency Room	None	1	2	3	4	5 or more
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If one or more, describe

visits were related to: Vomiting, dehydration, UTI

C. Stayed in the hospital overnight	None	1	2	3	4	5 or more
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If one or more, describe

tx for UTI

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

R 2nd toe amputation January 2021

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

☒ Yes ☐ No

[Describe](#)

UTI- required a few days of IV abx

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

Physical Therapist	Yes	No
Comment: home PT- ended in June		
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
Comment: care giving is managed by family member's, also visited by HH nurse for wound care		
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
Comment: night time			
Wound Care	Yes	No	Unknown
Regular Injections	Yes	No	Unknown
Comment: insulin			
Tube Feedings	Yes	No	Unknown

Family History

26. Family History

☒ Yes ☐ No

Family Member	Medical Condition	Cause of Death
Other	sleep apnea	n/a
Other	cancer, DM	cancer

Preventive Care

27. In the past three years have you had?

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

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
- ☒ Pneumovax
 ☐ No
 ☒ Unknown
- ☒ Prevenar
 ☐ No
 ☒ Unknown

34. Have you been vaccinated for Herpes Zoster?

- ☐ Yes
 ☒ No

comments daughter helping him with visit is not aware if he had it

Allergies / Medications

35. Allergies

- ☒ Yes
 ☐ No

Substance	Reaction
PCN	hives, SOB
morphine	hives, SOB

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
glaucoma	PREDNISOLONE	SUS 1% OP	Select	Select	PCP	Taking	Not Taking
HTN	AMLODIPINE	TAB 5MG	Select	Select	PCP	Taking	Not Taking
BPH	FINASTERIDE	TAB 5MG	Select	Select	PCP	Taking	Not Taking
UTI	CEFUROXIME	TAB 500MG	Select	Select	urologist	Taking	Not Taking
UTI	NITROFURANTIN	CAP 100MG	Select	Select	urologist	Taking	Not Taking
BPH	TAMSULOSIN	CAP 0.4MG	Select	Select	urologist	Taking	Not Taking
hypothyroidism	LEVOTHYROXIN	TAB 50MCG	Select	Select	pcp	Taking	Not Taking
	BRIMONIDINE	SOL 0.2% OP	Select	Select		Taking	Not Taking
	FREESTYLE	KIT SENSOR	Select	Select		Taking	Not Taking
GERD	PANTOPRAZOLE	TAB 40MG	Select	Select	PCP	Taking	Not Taking
glaucoma	DORZOLAMIDE	SOL 2% OP	Select	Select	PCP	Taking	Not Taking
HTN	LOSARTAN POT	TAB 25MG	Select	Select	PCP	Taking	Not Taking
	BD PEN NEEDL	MIS 31GX8MM	Select	Select		Taking	Not Taking
RLS	ROPINIROLE	TAB 1MG	Select	QD	PCP	Taking	Not Taking
unknown	ACYCLOVIR	CAP 200MG	Select	QD	PCP	Taking	Not Taking
neuropathy	GABAPENTIN	TAB 600MG	Select	TID	PCP	Taking	Not Taking
glaucoma	LATANOPROST	SOL 0.00005	Select	Select	PCP	Taking	Not Taking
DM	LANTUS SOLOS	INJ 100/ML	Select	Select	PCP	Taking	Not Taking
	OMEPRAZOLE	CAP 20MG DR	Select	Select		Taking	Not Taking
pain control	HYDROCO/APAP	TAB 5-325MG	Select	PRN	PCP	Taking	Not Taking
	CEPHALEXIN	CAP 500MG	Select	Select		Taking	Not Taking
depression	DULOXETINE	CAP 30MG	Select	Select	PCP	Taking	Not Taking
	COLCHICINE	TAB 0.6MG	Select	Select		Taking	Not Taking
a fib	CLOPIDOGREL	TAB 75MG	Select	Select	PCP	Taking	Not Taking
seasonal allergies	HYDROXYZHCL	TAB 10MG	Select	QD	PCP	Taking	Not Taking

	ELIQUIS	TAB 2.5MG	Select	Select		Taking	Not Taking
	CIPROFLOX ACN	TAB 500MG	Select	Select		Taking	Not Taking
	DOXYCYCL HYC	CAP 100MG	Select	Select		Taking	Not Taking
	CEFDINIR	CAP 300MG	Select	Select		Taking	Not Taking
depression	CITALOPRA M	TAB 10MG	Select	Select	PCP	Taking	Not Taking
DM	NOVOLIN	INJ 70/30 FP	SQ = Subcutaneous	BID	PCP	Taking	Not Taking
hyperlipidemia	ATORVASTATIN	TAB 40MG	Select	Select	PCP	Taking	Not Taking
	OFLOXACIN	DRO 0.3% OP	Select	Select		Taking	Not Taking

36. Over the Counter Medications / Supplements

☒ Yes ☐ No

Date	Description	Dose/Units	Route	Frequency
07-17-2021	tylenol	650mg	PO = By Mouth	PRN

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

Difficulty with vision

↳ **Describe**

☒ **Active**

☐ History of

☐ Rule out

↳ **Legally Blind**

☐ Yes

☒ **No**

Glaucoma

↳ **Describe**

☐ Active

☒ **History of**

☐ Rule out

comments

had eye surgery to help correct

↳ **Supported by**

☐ History

☒ **Symptoms**

☒ **Physical Findings**

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

↳ **Secondary to Diabetes**

☒ **Yes**

☐ No

↳ **Type**

☐ Open (Wide) Angle ☐ Closed (Narrow) Angle

comments

unknown

Do you wear glasses or contacts?

☒ **Yes**

☐ No

comments

distance/reading

↳ **Do you have trouble seeing even with glasses?**

☐ 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

↳ **Diagnoses**

☒ **Difficulty with Hearing**

☐ Legally Deaf

☐ Tinnitus

☐ Vertigo

☐ Other

Difficulty with Hearing

↳ **Describe**

☒ **Active**

☐ History of

☐ Rule out

Do you have trouble hearing when people talk to you?

☒ **Yes**

☐ No

Do you wear a hearing aid?

☒ **Yes**

☐ No

- ↳ How often do you wear it
 - ☒ Occasionally
 - ☐ Frequently
 - ☐ All of the time
- ↳ Do you still have trouble hearing with it?
 - ☐ Yes
 - ☒ No

Do you read lips?

- ☒ Yes
- ☐ No

Do you have ear pain or drainage?

- ☐ Yes
- ☒ No

Do you ever get dizzy?

- ☐ 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

seasonal allergies

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

- ☒ Yes
- ☐ No

↳ Diagnoses

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

Difficulty Chewing

↳ Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

comments

denture and partial per daughter report

↳ Because of pain

- ☐ Yes
- ☒ No

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
- ☐ Acute Upper Respiratory Infection
- ☐ Chronic Pulmonary Embolism

- ☐ Chronic Respiratory Failure
- ☒ **COPD**
- ☐ Hypoventilation secondary to Obesity
- ☐ Pneumonia
- ☐ Respirator Dependence/Tracheostomy Status
- ☐ Sarcoidosis
- ☐ Other
- ☐ Chronic Sputum Production
- ☐ Cystic Fibrosis
- ☐ Hypoxemia
- ☐ Pulmonary Fibrosis
- ☐ Respiratory Arrest
- ☐ Sleep Apnea
- ☐ Rule out
- ☐ XR results
- ☐ Decreased or prolonged breath sounds
- ☐ Brinchodilator medication
- ☐ History of
- ☐ Barrel Chest
- ☐ Clubbing
- ☐ Dyspnea on exertion
- ☒ **O2 use**
- ☐ Respirator
- ☐ Other
- ☐ Yes
- ☒ **No**
- ☐ Yes
- ☐ No
- ☐ Yes
- ☒ **No**

comments daughter at visit was not aware of inhaler

- ☐ Yes
- ☒ **No**

comments daughter at visit was not aware of inhaler

- ☐ Yes
- ☒ **No**

Use of Oxygen

- ☒ **Yes**
- ☐ No
- ☐ PRN
- ☐ Continuous
- ☐ Day
- ☒ **Night**

☐ Litres / Min
3L via NC

Shortness of breath

- ☒ **Yes**
- ☐ No

comments intermittent on exertion

Wheezing

- ☐ Yes
- ☒ **No**

Chronic Cough

- ☐ Yes
- ☒ **No**

Patient requires durable medical equipment

☒ Yes ☐ No

comments

uses O2 at night

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

☒ Yes ☐ No

Diagnoses

- | | |
|--|--|
| <input type="checkbox"/> Abnormal Cardiac Rhythm | <input type="checkbox"/> Aneurysm |
| <input type="checkbox"/> Angina | <input checked="" type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> Cardio – Respiratory Failure / Shock | <input type="checkbox"/> Cardiomyopathy |
| <input checked="" type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Deep Vein Thrombosis |
| <input checked="" type="checkbox"/> Hyperlipidemia | <input checked="" type="checkbox"/> Hypertension |
| <input type="checkbox"/> Ischemic Heart Disease (CAD) | <input type="checkbox"/> Myocardial Infarction |
| <input checked="" type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Pulmonary Hypertension |
| <input type="checkbox"/> Valvular Disease | <input type="checkbox"/> Other |

Atrial Fibrillation

Describe

☒ **Active** ☐ History of ☐ Rule out

Type

☐ Paroxysmal ☐ Chronic ☒ **Unknown**

Supported by

<input checked="" type="checkbox"/> Medications	<input checked="" type="checkbox"/> ECG	<input type="checkbox"/> Symptoms
<input type="checkbox"/> History	<input type="checkbox"/> Electric cardioversion	<input type="checkbox"/> Other

Is patient taking

☒ **Anticoagulant** ☐ Rate controlling medication ☐ Other

Congestive Heart Failure

Describe

☒ **Active** ☐ History of ☐ Rule out

Supported by

<input type="checkbox"/> Ejection fraction	<input type="checkbox"/> Cardiomegaly	<input type="checkbox"/> Orthopnea
<input checked="" type="checkbox"/> DOE	<input type="checkbox"/> PND	<input type="checkbox"/> S3
<input type="checkbox"/> Medications	<input checked="" type="checkbox"/> Peripheral edema	<input type="checkbox"/> Other

Describe

☐ Diastolic ☐ Systolic ☒ **Unknown**

Secondary to Hypertension

☒ **Yes** ☐ No

Is patient on an ACE or ARB

☒ **Yes** ☐ No

Is patient on a Beta Blocker

☐ Yes ☒ **No**

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

Peripheral Vascular Disease
 ↳ Describe
☒ Active
☐ History of
☐ Rule out

↳ Supported by
☐ Vascular studies
☒ Claudication
☒ Extremity Ulcers
☐ Diminished or absent pulses
☒ Amputation
☐ Other

↳ History Diabetes
☒ Yes
☐ No

↳ Describe
☒ Ulceration
☐ Gangrene

History of Chest Pain

☐ Yes ☒ No

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

Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Bowel Obstruction | <input type="checkbox"/> Cachexia |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Colon Polyps | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Gall Bladder Disease | <input type="checkbox"/> Gastroparesis |
| <input checked="" type="checkbox"/> GERD | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Inflammatory Bowel Disease | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Ulcer Disease | <input checked="" type="checkbox"/> Other |

GERD

Describe

☒ Active ☐ History of ☐ Rule out

Supported by

☒ Heartburn /
Dyspepsia ☐ Regurgitation ☒ Medications

☐ Other

Other

Describe

☒ Active ☐ History of ☐ Rule out

Supported by

☒ History ☐ Symptoms ☒ Physical Findings

☐ Medications ☐ Test results ☒ Image studies

☐ Biopsy ☐ DME ☐ Other

Other

comments

diverticulosis

History of blood in stool

☐ Yes ☒ No

History of black stools

☐ Yes ☒ No

History of Heartburn / Dyspepsia

☒ Yes ☐ No

Describe

☒ Occasionally ☐ Chronic

History of Vomiting or Regurgitation

☒ Yes ☐ No

Describe

☐ Blood ☒ Bile ☐ Coffee grounds

☐ Other

History of pain after eating

☐ Yes ☒ No

History of Jaundice

☐ Yes ☒ No

Do you follow a special diet?

☐ Yes ☒ No

Do you have frequent abnormal abdominal pain?

☐ Yes ☒ No

Do you have intermittent nausea or vomiting?

☒ Yes ☐ No

Do you have trouble with constipation?

☐ Yes ☒ No

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

☐ Yes ☒ No

Do you see blood in your urine?

☐ Yes ☒ No

Do you have Frequent Stomach Pain

☐ 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 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 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 | |

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

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

comments

if denture/partial are not in place

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

☐ Yes

☒ No

Do you trouble understanding what people say to you?

☒ Yes

☐ No

comments

if hearing aids are not in

Do your hands shake?

☐ Yes

☒ No

Do you have convulsions and seizures?

☐ Yes

☒ No

Do you have trouble with your memory?

☒ Yes

☐ No

comments daughter reports intermittent trouble with memory

Do you have trouble finding words?

☐ Yes ☒ No

Do you have trouble sleeping?

☐ Yes ☒ No

Have you lost your appetite

☐ Yes ☒ No

comments daughter reports "eats in spells"

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 ☐ No

☒ Patient oriented to place ☐ No

☐ Patient oriented to time ☒ No

comments was confused about year, first reported 2002

☒ Recall ☐ Poor

☐ Patient describes recent news event ☒ 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

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
- ☐ Limp
- ☐ Wide based
- ☐ Abductor lurch
- ☐ Paretic
- ☒ Shuffling
- ☐ Ataxic
- ☐ Other (Findings may also apply to Musculoskeletal diagnoses)

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

- ☒ Yes
- ☐ No

Diagnoses

- ☐ Acute Renal Failure
- ☒ Chronic Kidney Disease
- ☐ Erectile Dysfunction
- ☐ Kidney Stones
- ☐ Urinary Incontinence
- ☒ BPH
- ☐ ESRD
- ☒ Frequent UTI
- ☐ Nephritis or Nephrosis
- ☐ Other

comments

denies urinary/fecal incontinence

BPH

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☐ Physical exam
- ☐ Symptoms
- ☐ Lab test
- ☐ Biopsy
- ☒ Medication
- ☐ Hospitalization
- ☐ Other

Chronic Kidney Disease

- ↳ Describe
 - ☒ Active
 - ☐ History of
 - ☐ Rule out
- ↳ Supported by
 - ☒ Lab tests
 - ☐ Calculated GFR X 3
 - ☐ Other
- ↳ What stage
 - ☐ 1 [GFR > 89]
 - ☐ 2 [GFR 60-89]
 - ☒ 3 [GFR 30-59]
 - ☐ 4 [GFR15-29]
 - ☐ 5 [GFR <15]
- ↳ Secondary to Diabetes
 - ☒ Yes
 - ☐ No
- ↳ Secondary to Hypertension
 - ☒ Yes
 - ☐ No
- Frequent UTI
- ↳ Describe
 - ☒ Active
 - ☐ History of
 - ☐ Rule out
- ↳ Supported by
 - ☒ Symptoms
 - ☐ Cultures
 - ☐ Laboratory results
 - ☒ Other
- Other
- ↳ Describe

comments

on abx

History of frequency

☐ Yes ☒ No

History of Nocturia

☒ Yes ☐ No

↳

☒ 1x / night ☐ 2x / night ☐ 3x / night
☐ >=4x / night

History of Hesitancy

☐ Yes ☒ No

Do you have trouble urinating?

☐ Yes ☒ No

Do you ever have blood in your urine?

☐ 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 holding your urine?

☐ Yes ☒ No

Do you trouble getting to the bathroom on time?

☐ Yes ☒ No

Do you ever have pain or burning during urination?

☒ Yes ☐ No

Do you ever wear pads or diapers?

☐ Yes ☒ No

Do you have a vaginal discharge?

☐ Yes ☒ No

Do you have vaginal bleeding?

☐ Yes

☒ No

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

☐ Yes

☒ No

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

☒ Yes

☐ No

Diagnoses

☐ Basal Cell Carcinoma

☐ Eczema

☐ Skin ulcer

☒ Wound

☐ Wound

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ History

☒ Symptoms

☒ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Etiology

☐ Surgical

☒ Traumatic

☐ Burn

comments

right foot

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

comments

feet

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 Diabetes

☐ Other

- ↳ 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

unsure

- ↳ And Date

comments

unsure

- ↳ Met with a nurse or dietician for diabetic education

☐ Yes ☒ No

- ↳ Met with a diabetic educator

☐ Yes ☒ No

Peripheral Neuropathy secondary to Diabetes

- ↳ Describe

☒ Active ☐ History of ☐ Rule out

- ↳ Supported by

☐ Physical exam ☐ Skin lesions ☐ Foot deformity
☐ Surgical procedures ☒ Other

Other

- ↳ Describe

comments

medications- taking gabapentin and requip

- ↳ Patient sees Podiatrist

☒ Yes ☐ No

- ↳ How often

☐ Once a year ☒ Twice a year ☐ Quarterly

Peripheral Vascular Disease secondary to Diabetes

- ↳ Describe

☒ Active ☐ History of ☐ Rule out

- ↳ Supported by

☐ Physical exam ☒ Vascular studies ☐ Skin lesions
☐ Foot deformity ☐ Surgical procedures ☒ Intermittent claudication

☐ Other

- ↳ Patient sees Podiatrist

☒ Yes ☐ No

- ↳ How often

☐ Once a year ☒ Twice a year ☐ Quarterly

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

comments

deny anemia history

Cancer

Diagnosis of Cancer	Yes	No
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Describe

☐ Active ☒ History of ☐ Rule out

Supported by

☒ Physical findings ☐ Hospitalization ☐ Treatments
☒ Lab tests ☐ Imaging studies ☐ Surgery
☐ Biopsy ☐ Other

Type

☐ Brain ☐ Head ☐ Neck
☐ Breast ☐ Lung ☐ Esophagus
☐ Stomach ☐ Liver ☐ Pancreas
☐ Colon ☐ Rectum ☐ Kidney
☐ Bladder ☐ Ovaries ☐ Uterus
☒ Prostate ☐ Bone ☐ Blood
☐ Lymph Nodes ☐ Skin ☐ Other

Specific type/s

unsure

Stage or Classification specific to the cancer

unsure

Active treatment

☐ Yes ☒ No

History / Finding of Metastasis

☐ Yes ☒ No

Do you see a specialist?

☒ Yes ☐ No

Provider

urologist- cannot recall name

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

legs

Do you take Methadone

☐ Yes ☒ No

What drug/s do you take for it

gabapentin, requip, tylenol, hydrocodone

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

5/10

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

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
104 (mmHG)	40 (mmHG)	68 (bpm)	16			5/10

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	9 (Inch)	123 (lbs)	18.2

☐ Obesity (BMI 30 – 34.9) ☐ Moderate Obesity (BMI 35 – 39.9) ☐ Morbid Obesity (BMI = or > 40)

☒ **Malnutrition (BMI < 18.5)**

↳ Describe

☐ Active

☐ History of

☒ **Rule out**

↳ Malnutrition

☐ Yes

☒ **No**

↳ Supported by

☐ Albumin < 3.5 g/dl

☒ **Muscle wasting**

☐ History of severe weight loss

Exam Review

Constitutional

General appearance:	Normal	Abnormal
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Head and Face

Examination of head and face:	Normal	Abnormal
Palpation of the face and sinuses:	Normal	Abnormal

Comment: unable to perform, virtual visit

Eyes

Inspection of conjunctiva and lids:	Normal	Abnormal
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Examination of pupils and irises:	Normal	Abnormal
Comment: unable to perform, virtual visit		

Ears, Nose, Mouth and Throat

External Inspection of ears and nose:	Normal	Abnormal
Otoscopic examination:	Normal	Abnormal
Comment: unable to perform, virtual visit		

Assessment of hearing:	Normal	Abnormal
Comment: bilateral hearing aids		

Inspection of nasal mucosa, septum and trubينات:	Normal	Abnormal
Comment: unable to perform, virtual visit		

Inspection of lips, teeth and gums:	Normal	Abnormal
Comment: missing teeth, does not have denture/partial in place		

Examination of oropharynx:	Normal	Abnormal
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Neck

Examination of neck:	Normal	Abnormal
Examination of thyroid:	Normal	Abnormal
Comment: unable to perform, virtual visit		

Pulmonary

Assessment of respiratory effort:	Normal	Abnormal
Percussion of chest:	Normal	Abnormal
Comment: unable to perform, virtual visit		

Palpation of chest:	Normal	Abnormal
Comment: unable to perform, virtual visit		

Auscultation of lungs:	Normal	Abnormal
Comment: unable to perform, virtual visit		

Cardiovascular

Palpation of heart:	Normal	Abnormal
Comment: unable to perform, virtual visit		

Auscultation of heart:	Normal	Abnormal
Comment: unable to perform, virtual visit		

Carotid Arteries:	Normal	Abnormal
Comment: unable to perform, virtual visit		
Abdominal Aorta:	Normal	Abnormal
Comment: unable to perform, virtual visit		
Pedal Pulses:	Normal	Abnormal
Comment: unable to perform, virtual visit		
Examination of Arterial Pulses:	Normal	Abnormal
Comment: unable to perform, virtual visit		
Examination of Edema / Varicosities:	Normal	Abnormal
Comment: trace bilateral lower extremities		

Lymphatic

Palpation of cervical nodes (neck)	Normal	Abnormal
Comment: unable to perform, virtual visit		
Palpation of preauricular nodes (in front of the ears)	Normal	Abnormal
Comment: unable to perform, virtual visit		
Palpation of Submandibular nodes (under jaw line/chin)	Normal	Abnormal
Comment: unable to perform, virtual visit		

Musculoskeletal

Examination of gait and station:	Normal	Abnormal
Comment: shuffles		
Inspection/palpation of digits and nails:	Normal	Abnormal
Comment: normal inspection, unable to palpate		
Inspection/palpation of joints, bones and muscles:	Normal	Abnormal
Comment: normal inspection, unable to palpate		
Assessment of range of motion:	Normal	Abnormal
Assessment of stability:	Normal	Abnormal
Comment: slow, shuffling gate		
Assessment of muscle strength/tone:	Normal	Abnormal

Skin

Inspection of skin and subcutaneous tissue:	Normal	Abnormal
Comment: dressing in place, right foot		

Palpation of skin and subcutaneous tissue:	Normal	Abnormal
Comment: unable to perform, virtual visit		

Neurologic

Indicate specific cranial nerve tested

able to smile, stick tongue out, puff cheeks, raise shoulders, and move head/eyes side to side and up/down

Indicate cranial nerve deficits found

n/a

Romberg Test	Normal	Abnormal
Comment: unable to perform, virtual visit		

Examination of reflexes:	Normal	Abnormal
Comment: unable to perform, virtual visit		

Examination of sensation:	Normal	Abnormal
Comment: unable to perform, virtual visit		

Coordination:	Normal	Abnormal
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Diabetes

Foot Exam:	Normal	Abnormal
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☒ RFoot

☐ LFoot

☐ Bilateral

Comments: dressing in place is clean, dry, and intact

Psychiatric

Description of patient's judgement / insight:	Normal	Abnormal
Orientation of person, place and time:	Normal	Abnormal
Recent and remote memory:	Normal	Abnormal
Comment: watches the news but cannot recall recent news story		

Mood and affect:	Normal	Abnormal
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Screenings Needed

Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnoses	Comments
DIGITAL_RETINAL	Yes	Select			No				

↳ Worries about falling or feeling unsteady when standing or walking?

☐ Yes ☒ No

↳ Did you have a fracture in past 6 months?

☐ Yes ☒ No

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?

"no"

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

"no"

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 :

After confirmation of patient's name and DOB a virtual visit was performed. Information was provided by the patient with assistance from his daughter. The patient was pleasant and appropriate during the visit and answered all questions. Part of the physical exam including auscultation and palpation were not able to be assessed due to the nature of a virtual visit. Inspection and direct visualization were utilized to assess appearance/normal variance. All questions were answered

and they understand further communication will be provided by focus care if there are any additional questions or concerns. Of note, the patient/his daughter deny anemia, urinary/fecal incontinence, sleep apnea, and liver disease. We discussed appropriate nutrition including adequate water intake, protein, and boost/ensure.

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 :	2021-07-17T11:00
Time exam finished	2021-07-17T12:15
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Consented to Video chat	<input checked="" type="checkbox"/>
Provider Signature	 <div>Digitally signed by Lindsay Otis, NP 2021-07-17, 12:27</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?