

HRA Form

|                   |                                       |
|-------------------|---------------------------------------|
| Health Plan :     | Virginia Premier Healthcare Advantage |
| Member Name :     | JUDY G BRUCE                          |
| Evaluator Name :  | test clinicianFE, FNP                 |
| Assessment Type : | Health Risk Assessment                |
| DOB :             | 1953-09-28                            |
| Evaluation Date : | 2022-4-5 05:44 PM                     |
| Visit Type :      | In Person                             |

Demographics

|                              |                         |
|------------------------------|-------------------------|
| Plan                         | VPHP - VIRGINIA PREMIER |
| Program                      | Medicare                |
| LOB                          | DSNP                    |
| Name                         | JUDY G BRUCE            |
| Gender                       | Female                  |
| Address                      | 517 E SYCAMORE STREET   |
| City                         | CHASE CITY              |
| State                        | VA                      |
| Zip                          | 239242007               |
| Date of Birth                | 1953-09-28              |
| Age(as of date)              | 68                      |
| Marital Status               |                         |
| Member Identification Number | 11007868                |
| HICN                         | 6V00J36UE12             |
| Phone Number                 | 8045131890              |
| Cell Number                  |                         |
| Alternate Contact Number     |                         |
| Email                        |                         |
| Emergency Contact            |                         |
| Phone Number                 |                         |
| Primary Care Physician       | SUSLICK, RANDALL H      |
| Phone Number                 | 4343725141              |
| PCP Address                  | 115 College St          |
| PCP City                     | Clarksville             |
| PCP State                    | VA                      |

|             |                             |
|-------------|-----------------------------|
| PCP Zip     | 239279125                   |
| PCP County  |                             |
| Office ID   | P0060096                    |
| Office Name | CLARKSVILLE FAMILY PRACTICE |

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

## Previously Documented Conditions

## Covid Screening

### In the last 14 days, have you:

|  |     |    |
|--|-----|----|
| Traveled internationally?  | Yes | No |
| Had known exposure to anyone diagnosed with Corona virus (COVID-19)  | Yes | No |
| Had close contact with someone who has traveled to a high risk area? | Yes | No |
| Developed Fever?   | Yes | No |

|                                |   |                             |
|--------------------------------|---|-----------------------------|
| Developed Cough?               | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| Developed Flu like symptoms?   | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
| Developed Shortness of breath? | <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |

### Self-Assessment and Social History

3. How much school have you completed?

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

4. When you get written information at a doctor's office would you say it is

- ☒ **Very difficult**
☐ Somewhat difficult
 ☐ Easy  
☐ Very easy to understand

5. When you read the instructions on a prescription bottle would you say that it is

- ☒ **Very difficult**
☐ Somewhat difficult
 ☐ Easy  
☐ Very easy to understand

6. How confident are you in filling out medical forms by yourself?

- ☒ **Not at All Confident**
☐ Not Very Confident
 ☐ Confident  
☐ Very Confident

7. How would you rate your health compared to other persons your age?

- ☒ **Excellent**
☐ Good
 ☐ Fair  
☐ Poor

8. During past 3 months, has your physical and or emotional health limited your social activities with family, friends, neighbours or groups?

- ☒ **Often**
☐ Sometimes
 ☐ Almost Never  
☐ Never

9. Where do you currently live?

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

10. Do you have someone you can rely on to help if you are sick or have problems you need to discuss?

- ☒ **Yes**
☐ No

comments

Comments

11. Who do you currently live with?

- ☒ **Alone**
☐ Spouse
 ☐ Partner  
☐ Relative
 ☐ Family
 ☐ Friend  
☐ Personal Care Worker

Describe  
ALONE

12. Are you currently a caregiver for someone?

- ☒ **Yes**
☐ No

Describe

YES IT IS

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

| How many drinks | How Often |
|-----------------|-----------|
| 2               | Day       |

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

☒ Yes

☐ No

Which drugs or medication

DRUGS MEDICATIONS

16. Do you have a Healthcare Proxy?

☒ Yes

☐ No

☐ Don't Know

Name

NEMR

Relationship

RELATIOSN

17. Do you have a Durable Power of Attorney?

☒ Yes

☐ No

☐ Don't Know

Name

TYESD

Relationship

RE;ATGR

18. Do you have an Advance Directive?

☒ Yes

☐ No

☐ Don't Know

Where is it kept?

AT HOSPITAL

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

|                            |    |                |                 |
|----------------------------|----|----------------|-----------------|
| 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**

21. Are you currently seeing any specialists?

☒ **Yes**

☐ No

| Medical Specialty | Specialist | For |
|-------------------|------------|-----|
|-------------------|------------|-----|

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

**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

## Preventive Care

**27. In the past three years have you had?**

| Screen                  | Answer |
|-------------------------|--------|
| Colonoscopy             | select |
| Breast Exam/Mammography | select |
| Cervical Screening      | select |
| Bone Density            | select |
| Prostate Exam/PSA       | select |

|                            |        |
|----------------------------|--------|
| If Diabetic Eye Exam       | select |
| If Diabetic Foot Exam      | select |
| If Diabetic Hgb A1c screen | select |
| Lipid Panel                | select |

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

34. Have you been vaccinated for Herpes Zoster?

- ☐ Yes
 ☒ No

## Allergies / Medications

### 35. Allergies

- ☐ Yes
 ☒ No

### Medications

| Diagnoses | Label Name   | Dose / Units | Route  | Frequency | Prescribing Physician | Status |            |
|-----------|--------------|--------------|--------|-----------|-----------------------|--------|------------|
|           | CARVEDILOL   | TAB 6.25MG   | Select | Select    |                       | Taking | Not Taking |
|           | HYDRALAZINE  | TAB 10MG     | Select | Select    |                       | Taking | Not Taking |
|           | ATORVASTATIN | TAB 20MG     | Select | Select    |                       | Taking | Not Taking |
|           | FUROSEMIDE   | TAB 20MG     | Select | Select    |                       | Taking | Not Taking |
|           | AMIODARONE   | TAB 200MG    | Select | Select    |                       | Taking | Not Taking |
|           | SPIRONOLACT  | TAB 25MG     | Select | Select    |                       | Taking | Not Taking |
|           | ELIQUIS      | TAB 5MG      | Select | Select    |                       | Taking | Not Taking |
|           | DIGOXIN      | TAB          | Select | Select    |                       | Taking | Not Taking |

|  |              |             |        |        |  |        |            |
|--|--------------|-------------|--------|--------|--|--------|------------|
|  |              | 0.125MG     |        |        |  |        |            |
|  | QUETIAPINE   | TAB 50MG    | Select | Select |  | Taking | Not Taking |
|  | KETOCONAZOLE | CRE 0.02    | Select | Select |  | Taking | Not Taking |
|  | CARVEDILOL   | TAB 6.25MG  | Select | Select |  | Taking | Not Taking |
|  | ATORVASTATIN | TAB 20MG    | Select | Select |  | Taking | Not Taking |
|  | HYDRALAZINE  | TAB 10MG    | Select | Select |  | Taking | Not Taking |
|  | SPIRONOLACT  | TAB 25MG    | Select | Select |  | Taking | Not Taking |
|  | FUROSEMIDE   | TAB 20MG    | Select | Select |  | Taking | Not Taking |
|  | AMIODARONE   | TAB 200MG   | Select | Select |  | Taking | Not Taking |
|  | ELIQUIS      | TAB 5MG     | Select | Select |  | Taking | Not Taking |
|  | DIGOXIN      | TAB 0.125MG | Select | Select |  | Taking | Not Taking |
|  | KETOCONAZOLE | CRE 0.02    | Select | Select |  | Taking | Not Taking |

36. Over the Counter Medications / Supplements

☐ Yes

☒ No

37. Chronic Use of

☒ None

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

Do you wear glasses or contacts?

☐ Yes

☒ No

Do you have problems seeing at night?

☐ Yes

☒ No



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

☐ Yes ☒ No

### Nose Problems (Nose Bleeds, Sinus infections, Other)

☐ Yes ☒ No

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

☐ Yes ☐ No

### Neck Problems (parotid Disease, Carotid Stenosis, Other)

☐ Yes ☒ No

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

☐ Yes ☒ No

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

☐ Yes ☒ No

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

☐ Yes ☐ No

### Bowel Movements

☐ Normal ☒ Abnormal

☒ If abnormal

☐ Constipation

☒ Diarrhea

☐ Bowel Incontinence

### 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

### 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

### How often do you go out to meet with family or friends

☐ Often ☐ Sometimes ☒ Never

## GPCOG Score or MMSE Score

| GPCOG Score | or MMSE Score |
|-------------|---------------|
|             |               |

If GPCOG or MMSE is not done, is

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

Affect

- ☐ Normal ☒ Abnormal
  - ↳ If abnormal,
    - ☐ Paranoia ☐ Delusional ☐ Disorganized thought
    - ☐ Flat ☐ Manic ☐ Depressed
    - ☒ Other

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
  - ↳ If abnormal
    - ☐ Left ☒ Right ☐ Both

Heel (Shin) to Toe

- ☐ Normal ☒ Abnormal
  - ↳ If abnormal
    - ☐ Left ☒ Right ☐ Both

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

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

☐ Yes

☐ No

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

☐ Yes

☐ No

### Endocrine Problems

☐ 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

### Cancer

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

### Pain

Does the patient experience pain?

☐ Yes

☐ No

## Vital Signs

### Vital Signs

| Blood Pressure |        | Pulse | Respiratory Rate | Temp | Pulse Oximetry | Pain Scale /10 |
|----------------|--------|-------|------------------|------|----------------|----------------|
| (mmHG)         | (mmHG) | (bpm) |                  |      |                |                |

### BMI

| Patients Height |        | Patients Weight | Calculate BMI |
|-----------------|--------|-----------------|---------------|
| (Feet)          | (Inch) | (lbs)           |               |

- ☐ 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 |
| Examination of oropharynx:                       | Normal | Abnormal |

### Neck

|                      |        |          |
|----------------------|--------|----------|
| Examination of neck: | Normal | Abnormal |
|----------------------|--------|----------|

|                         |        |          |
|-------------------------|--------|----------|
| Examination of thyroid: | Normal | Abnormal |
|-------------------------|--------|----------|

Pulmonary

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

Cardiovascular

|                                      |        |          |
|--------------------------------------|--------|----------|
| Palpation of heart:                  | Normal | Abnormal |
| Auscultation of heart:               | Normal | Abnormal |
| Carotid Arteries:                    | Normal | Abnormal |
| Abdominal Aorta:                     | Normal | Abnormal |
| Pedal Pulses:                        | Normal | Abnormal |
| Examination of Arterial Pulses:      | Normal | Abnormal |
| Examination of Edema / Varicosities: | Normal | Abnormal |

Lymphatic

|  |        |          |
|--|--------|----------|
| Palpation of cervical nodes (neck)                     | Normal | Abnormal |
| Palpation of preauricular nodes (in front of the ears) | Normal | Abnormal |
| Palpation of Submandibular nodes (under jaw line/chin) | Normal | Abnormal |

Musculoskeletal

|  |        |          |
|--|--------|----------|
| Examination of gait and station:                   | Normal | Abnormal |
| Inspection/palpation of digits and nails:          | Normal | Abnormal |
| Inspection/palpation of joints, bones and muscles: | Normal | Abnormal |
| Assessment of range of motion:                     | Normal | Abnormal |
| Assessment of stability:                           | Normal | Abnormal |
| Assessment of muscle strength/tone:                | Normal | Abnormal |

Skin

|   |        |          |
|---|--------|----------|
| Inspection of skin and subcutaneous tissue: | Normal | Abnormal |
| Palpation of skin and subcutaneous tissue:  | Normal | Abnormal |

Neurologic

Indicate specific cranial nerve tested  
Indicate cranial nerve deficits found

|              |        |          |
|--------------|--------|----------|
| Romberg Test | Normal | Abnormal |
|--------------|--------|----------|

|                           |        |          |
|---------------------------|--------|----------|
| 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 | Diagnoses | 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

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 : --

Person's Answers: --

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

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

44. Have you ever physically or felt emotionally abused by someone

- ☐ Yes
- ☐ No

45. Feeling like harming others or yourself

☐ Yes

☐ No

#### 46. Are you afraid of anyone or is anyone hurting you?

☐ Yes


☐ No

### Patient Summary

#### Assessors Comments :

#### Member 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 type="checkbox"/>  |
| Date/Time of Service/Evaluation : | 2022-04-05T18:00  |
| Time exam finished                | 2022-04-05T20:00  |
| I accept the Disclosure Statement | <input checked="" type="checkbox"/>   |
| Provider Signature                | <div> <div>shwe</div> <div>  <p>Digitally signed by<br/>test<br/>clinicianFE,<br/>FNP<br/>2022-04-08, 01:30</p> </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?