

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	KAREN CARTER
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1954-04-07
Evaluation Date :	2021-7-24 08:00 AM
Visit Type :	

Demographics

Plan	VPHP - VIRGINIA PREMIER
Program	MEDICARE
LOB	DSNP
Name	KAREN CARTER
Gender	Female
Address	25614 Simmons Avenue
City	NORTH DINWIDDIE
State	VA
Zip	23831-0000
Date of Birth	1954-04-07
Age(as of date)	67
Marital Status	Married
Member Identification Number	11008383
HICN	5E75PD9VM84
Phone Number	8043100479
Cell Number	
Alternate Contact Number	
Email	
Emergency Contact	Jerry Carter
Phone Number	804-363-6669
Primary Care Physician	Dr. Andrew Rose
Phone Number	8047489071
PCP Address	12801 IRON BRIDGE ROAD
PCP City	CHESTER
PCP State	VA

PCP Zip	238310000
PCP County	CHESTERFIELD
Office ID	P0125636
Office Name	SOUTHSIDE PHYSICIAN NETWORK 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**

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

 Describe

Her mother is currently in hospice care

13. Tobacco use

- ☐ Current
- ☐ Former
- ☒ Never

14. Alcohol Use

- ☒ Current
- ☐ Former
- ☐ Never

How many drinks	How Often
1	Day

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

- ☐ Yes
- ☒ No

16. Do you have a Healthcare Proxy?

☐ Yes ☒ No ☐ Don't Know

17. Do you have a Durable Power of Attorney?

☐ Yes ☒ No ☐ Don't Know

18. Do you have an Advance Directive?

☐ Yes ☒ No ☐ Don't Know

Within the past 12 months we worried whether our food would run out before we got money to buy more. Was that _____ for your household?

☐ Often True ☐ Sometimes True ☒ Never True

Within the past 12 months the food we bought just didn't last and we didn't have money to get more. Was that _____ for your household?

☐ Often True ☐ Sometimes True ☒ Never True

Activities of Daily Living

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

A. Getting in or out of bed	No	Need Some Help	Need Total Help
B. Getting in or out of chairs	No	Need Some Help	Need Total Help
C. Toileting	No	Need Some Help	Need Total Help
D. Bathing	No	Need Some Help	Need Total Help
E. Dressing	No	Need Some Help	Need Total Help
F. Eating	No	Need Some Help	Need Total Help
G. Walking	No	Need Some Help	Need Total Help
H. Going up or down stairs	No	Need Some Help	Need Total Help

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
Psychiatrist	Dr. Snow	mental health

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

 If one or more, describe

UTI

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

Family Member	Medical Condition	Cause of Death
Mother	congenital heart failure, enlargement of liver	still living
Father	heart disease	heart attack
Sibling1	1 sister 2 brothers - fatty liver, back pain,	still living

	kidney disease, mental illness	
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Preventive Care

27. In the past three years have you had?

Screen	Answer
Colonoscopy	No
Breast Exam/Mammography	Yes
Cervical Screening	Yes
Bone Density	Yes
Prostate Exam/PSA	Not Applicable
If Diabetic Eye Exam	Not Applicable
If Diabetic Foot Exam	Not Applicable
If Diabetic Hgb A1c screen	Not Applicable
Lipid Panel	Yes

28. Last colonoscopy if more than 2 years ago

- ☐ 3 – 5 years ago
- ☐ 6 – 10 years ago
- ☐ > 10 years ago
- ☒ **Never**
- ☐ Don't know

comments

Educated patient on the importance of getting a colonoscopy. She reported that she was still not interested but stated that she would consider getting a cologuard in the mean time and would discuss this with her provider.

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

comments

Educated patient on the importance of getting screened for Hepatitis C. She will discuss this at her next provider office visit.

32. Do you get Flu Vaccine each year?

- ☒ **Yes**
- ☐ No

33. Have you been vaccinated for Pneumonia?

- ☐ Yes
- ☒ **No**

comments

Educated patient on the importance of getting vaccinated against pneumonia and she will discuss this with her provider at her next visit.

34. Have you been vaccinated for Herpes Zoster?

- ☐ Yes
- ☒ **No**

comments

Educated patient on the importance of getting vaccinated against Shingles. She will discuss this with her provider at her next office visit.

Allergies / Medications

35. Allergies

☒ Yes

☐ No

Substance	Reaction
Penicillin	rash
Benadryl	makes her hyper
Zoloft	adverse reaction

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status	
Bipolar	VRAYLAR	CAP 1.5MG	PO = By Mouth	QD	Dr. Snow	Taking	Not Taking
Insomnia	TRAZODONE	TAB 100MG	PO = By Mouth	QPM	Dr. Snow	Taking	Not Taking
Depression	FLUOXETINE	CAP 60MG	PO = By Mouth	QD	Dr. Snow	Taking	Not Taking
Depression	CLONAZEP ODT	TAB 1MG	PO = By Mouth	QD	Dr. Snow	Taking	Not Taking
Hip pain	TRAMADOL HCL	TAB 50MG	PO = By Mouth	PRN	Dr. Rose	Taking	Not Taking
UTI	Bactrim	TAB 800MG	PO = By Mouth	BID	Dr. Rose	Taking	Not Taking

36. Over the Counter Medications / Supplements

☒ Yes

☐ No

Date	Description	Dose/Units	Route	Frequency
07-24-2021	Monistat	1 application		topical cream PRN

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
Comment: She is setting alarms in her phone to help her remember.		
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

☐ Glaucoma

☐ Macular Degeneration

☐ Retinal Disease

☒ Difficulty with vision

☐ Hyperopia

☐ Myopia

☐ Others

Difficulty with vision

Describe

☒ Active

☐ History of

☐ Rule out

comments

bilateral presbyopia and myopia

Legally Blind

☐ Yes

☒ No

Do you wear glasses or contacts?

☒ Yes

☐ No

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

Nose Problems (Nose Bleeds, Sinus infections, Other)

☒ Yes

☐ No

Diagnoses

☐ Chronic Post Nasal Drip

☐ Nose Bleeds

☒ Sinus Infections

☐ Other

Sinus Infections

Describe

☒ Active

☐ History Of

☐ Rule out

comments

occasionally

Supported by

☒ History

☒ Symptoms

☐ Physical Findings

- ☐ Medications
- ☐ Test results
- ☐ Image studies
- ☐ Biopsy
- ☐ DME
- ☐ Other

comments

last one dated a month ago - pressure in her head, throat, and gum area

- ↳ Exudate

☒ Clear

☐ Purulent

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

Abdominal Openings

☐ Yes

☒ No

Rectal Problems

☐ Yes

☒ No

Last Bowel Movement

☐ Today

☒ 1-3 days ago

☐ >3 days ago

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

☒ Yes

☐ No

- ↳ Diagnoses

☐ Alcohol Dependence

☒ Bipolar Disorder

☐ Cerebral Palsy

☐ Dementia

☐ Drug Dependence

☒ Generalized Anxiety Disorder

☐ Hemiparesis

☒ Insomnia

☐ Migraine Headaches

☐ Amyotrophic Lateral Sclerosis

☐ Cerebral Hemorrhage

☐ Delusional Disease

☒ Depression

☐ Fibromyalgia

☐ Guillain-Barre Disease

☐ Huntington's Chorea

☐ Intellectual and or Developmental Disability

☐ Multiple Sclerosis

- ☐ Muscular Dystrophy

☐ Parkinson’s disease

☐ Restless leg syndrome

☐ Seizure Disorder

☐ Stroke

☐ TIA

☐ Other
- ☐ Myasthenia Gravis

☐ Peripheral Neuropathy

☐ Schizophrenia

☐ Spinal Cord Injury

☐ Subdural Hematoma

☐ Traumatic Brain Injury

Bipolar Disorder

- ☒ Describe

☒ Active

☐ History of

☐ Rule out
- ☒ Supported by

☐ History of mood swings

☒ Medication

☐ Other

comments

Taking Vraylar

Depression

- ☒ Describe

☒ Active

☐ History of

☐ Rule out
- ☒ Supported by

☐ Symptoms

☐ PHQ 2 / 9

☒ Use of antidepressant medication
- ☐ Other

comments

Taking Fluoxetine

- ☒ Major

☒ Yes

☐ NO
- ☒ Supported by

☐ PHQ 9

☐ Hospitalization

☒ Chronic use of antidepressant medication beyond 6 months
- ☐ Use of ECT

Generalized Anxiety Disorder

- ☒ Describe

☒ Active

☐ History of

☐ Rule out
- ☒ Supported by

☐ Symptoms

☐ GAD 7

☒ Antianxiety medication
- ☐ Other

comments

Taking clonazepam

Insomnia

- ☒ Describe

☒ Active

☐ History Of

☐ Rule out
- ☒ Supported by

☒ Medication

☐ Symptoms

☐ History
- ☐ Other

comments

Taking Trazodone

Are you nervous, anxious, feel on the edge or often feel stressed?

- | | | |
|--|--|--------------------------------|
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Do you worry too much about different things? | | |
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Do you feel afraid that something bad might happen? | | |
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | |
| History of headaches | | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | |
| History of auditory hallucinations | | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | |
| History of visual hallucinations | | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | |
| History of psychotic behavior | | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | |
| History of episodes of delirium | | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | |
| Do you follow a special diet? | | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> 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? | | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | |
| Do you have trouble swallowing your food? | | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | |
| Do you have trouble making people understand you when you speak? | | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | |
| Do you trouble understanding what people say to you? | | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | |
| Do your hands shake? | | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | |
| Do you have convulsions and seizures? | | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | |
| Do you have trouble with your memory? | | |
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Do you have trouble finding words? | | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | |
| Do you have trouble sleeping? | | |
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Have you lost your appetite | | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | |
| Do you hear voices or see things that other people do not | | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | |
| Do you have highs and lows | | |
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No | |
| Do you ever feel like someone is out to get you | | |
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No | |
| How often do you go out to meet with family or friends | | |
| <input checked="" type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |

GPCOG Score or MMSE Score

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

If GPCOG or MMSE is not done, is

- ☒ Yes

☐ No
- ☒ Yes

☐ No
- ☒ Yes

☐ No
- ☒ Good

☐ Poor
- ☒ Yes

☐ Partially

☐ No

Affect

☒ Normal

☐ Abnormal

Over the past 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things	Not at all	Several Days	More than half the days	Nearly every day
Feeling down, depressed or hopeless	Not at all	Several Days	More than half the days	Nearly every day

PHQ 2 Score

☐ < 3

☒ 3 or more

DEPRESSION SCREENING PHQ9

Having little interest or pleasure in doing things?

☐ Not at all

☐ Several

☐ More than half the days

☒ Nearly Every Day

Feeling down, depressed or hopeless at times?

☐ Not at all

☐ Several

☐ More than half the days

☒ Nearly Every Day

Do you have trouble falling or staying asleep, sleeping too much?

☐ Not at all

☐ Several

☒ More than half the days

☐ Nearly Every Day

Do you feeling tired or having little energy?

☐ Not at all

☒ Several

☐ More than half the days

☐ Nearly Every Day

Do you have a poor appetite or overeating?

☐ Not at all

☒ Several

☐ More than half the days

☐ Nearly Every Day

Feeling bad about yourself or that you are a failure or have let yourself or your family down?

☐ Not at all
 ☒ **Several**
☐ More than half the days
 ☐ Nearly Every Day

Trouble concentrating on things, such as reading the newspaper or watching TV?

☒ **Not at all**
☐ Several
 ☐ More than half the days
 ☐ Nearly Every Day

Moving or speaking so slowly that other people have noticed. Or opposite-being fidgety or restless that you have been moving around a lot more than usual?

☐ Not at all
 ☒ **Several**
☐ More than half the days
 ☐ Nearly Every Day

Thoughts that you would be better off dead, or hurting yourself?

☒ **Not at all**
☐ Several
 ☐ More than half the days
 ☐ Nearly Every Day

PHQ 9 Score

18

If Score is Greater than 15, recommend additional treatment

Speech

☒ **Normal**
☐ Slurred
 ☐ Aphasic
 ☐ Apraxia

Finger to Nose

☒ **Normal**
☐ Abnormal

Heel (Shin) to Toe

☒ **Normal**
☐ Abnormal

Thumb to Finger Tips

☒ **Normal**
☐ Abnormal

Sitting to Standing

☒ **Normal**
☐ Needs Assistance
 ☐ Unable

Facial / Extremity Movement

☐ Motor Tic
 ☐ Vocal Tic
 ☐ Benign (Essential Tremor)
 ☐ Intention Tremor
 ☐ Non-Intention (Pill rolling) Tremor
 ☐ Rigidity
 ☐ Spasticity
 ☐ Chorea Movement
 ☐ Cog wheeling
 ☒ **Normal**

Gait

☒ **Normal**
☐ Limp
 ☐ Wide based

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

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

- ☒ Yes ☐ No

Diagnoses

- | | |
|---|---|
| <input type="checkbox"/> Acute Renal Failure | <input type="checkbox"/> BPH |
| <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> ESRD |
| <input type="checkbox"/> Erectile Dysfunction | <input type="checkbox"/> Frequent UTI |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Nephritis or Nephrosis |
| <input type="checkbox"/> Urinary Incontinence | <input checked="" type="checkbox"/> Other |

Other

Describe

- ☒ Active

- ☐ History of

- ☐ Rule out

Supported by

- ☐ History

- ☐ Symptoms

- ☐ Physical Findings

- ☒ Medications

- ☐ Test results

- ☐ Image studies

- ☐ Biopsy

- ☐ DME

- ☐ Other

Other

comments

UTI - Taking Bactrim - 5 more days left on the medication
Yeast Infection - Taking Monistat

History of frequency

- ☐ Yes ☒ No

History of Nocturia

- ☐ Yes ☒ No

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

comments

due to the UTI

Do you ever wear pads or diapers?

- ☐ Yes ☒ No

Do you have a vaginal discharge?

- ☒ Yes ☐ No

comments

white thick cottage cheese - yeast infection

Do you have vaginal bleeding?

☐ Yes

☒ No

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

☒ Yes

☐ No

Diagnoses

- ☐ Collagen (Connective) Tissue Disease
- ☐ Degenerative Disc Disease
- ☐ Extremity Fracture (other than Hip)
- ☐ Gout
- ☐ Hallux Valgus
- ☐ Hammer Toes
- ☐ Onychomycosis
- ☒ Osteoarthritis
- ☐ Osteomyelitis
- ☐ Osteoporosis
- ☐ Pyogenic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Spinal Stenosis
- ☐ Systemic Lupus Erythematosus
- ☐ Tinea Pedis
- ☒ Other

Osteoarthritis

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

☐ Symptoms

☐ Physical Findings

☒ Image studies

☐ Other

Which joints

comments

history of right hip and bilateral knee replacement

Other

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ History

☐ Symptoms

☐ Physical Findings

☒ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Other

comments

right hip and lower back pain due to over use - Taking Tramadol

History / Finding of non- extremity Fracture

☐ Yes

☒ No

History / Finding of Hip Fracture / Dislocation

☐ Yes

☒ No

History / Finding of Vertebral Fracture

☐ Yes

☒ No

Do you have any swelling of your joints?

☒ Yes

☐ No

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

☒ Yes

☐ No

Do you have pain in your joints?

☒ Yes

☐ No

Do you have a problem straightening any joints?

☐ Yes

☒ No

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

☐ Yes

☒ No

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

comments

fractured left elbow it has been over 20 years ago.

☐ Yes

☒ No

Do you have constant pain in your bones?

☐ Yes

☒ No

Have you had an amputation?

☐ Yes

☒ No

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

☐ Yes

☒ No

Endocrine Problems

☒ None

☐ 5lbs

☐ 10lbs

☐ 15lbs

☐ More than 15lbs

☐ 10% of your weight
(calculated by assessor)

Have you lost weight in the past 6 months?

☒ Yes

☐ No

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

- Diagnoses

☐ AIDS

☐ C. Difficile

☐ HIV

☐ Hospital Acquired MRSA Infection

☐ Leukemia

☐ Multiple Myeloma

☐ Sickle Cell Disease

☐ Thalassemia

☐ Tuberculosis

☒ Other

Other

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ History

☐ Medications

☐ Biopsy

☐ Symptoms

☐ Test results

☐ DME

☐ Physical Findings

☐ Image studies

☐ Other

Other

comments

Factor 5 Lieden

☐ Yes

☒ No

Easy bruising or abnormal bleeding

Long term anticoagulation use

☐ Yes ☒ No

Cancer

Diagnosis of Cancer	Yes	No
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Pain

Does the patient experience pain?

☒ Yes ☐ No

Is the Pain Acute?

☒ Yes ☐ No

comments

lumbar spine and right hip pain due to overuse - Taking Tramadol 3-4/10 acny pain

Is the Pain Chronic?

☐ Yes ☒ No

Is the Patient Undergoing Pain Management Planning?

☐ Yes ☒ No

Was the patient advised regarding the potential for dependence?

☐ Yes ☒ No

Is there any evidence of Maladaptive Behavior?

Tolerance?

☐ Yes ☒ No

Withdrawal?

☐ Yes ☒ No

Increased usage over a longer period that intended?

☐ Yes ☒ No

Desire or unsuccessful effort to cut down on use?

☐ Yes ☒ No

Excess time spent in activities to obtain the substance?

☐ Yes ☒ No

Continued use despite Doctor advice or patient knowledge of habituation?

☐ Yes ☒ No

Physical or Psychological Problem related to the substance use?

☐ Yes ☒ No

Vital Signs

Vital Signs

comments

Unable to obtain a complete set of VS due to virtual visit.

Blood Pressure		Pulse	Respiratory Rate	Temp	Pulse Oximetry	Pain Scale /10
(mmHG)	(mmHG)	(bpm)				4

BMI

Patients Height		Patients Weight	Calculate BMI
5 (Feet)	3 (Inch)	160 (lbs)	28.3

- ☐ 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
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Head and Face

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

Eyes

Inspection of conjunctiva and lids:	Normal	Abnormal
Examination of pupils and irises:	Normal	Abnormal

Ears, Nose, Mouth and Throat

External Inspection of ears and nose:	Normal	Abnormal
Otoscopic examination:	Normal	Abnormal
Assessment of hearing:	Normal	Abnormal
Inspection of nasal mucosa, septum and trubينات:	Normal	Abnormal
Inspection of lips, teeth and gums:	Normal	Abnormal

Comment: The patient has no teeth present in her mouth.

Examination of oropharynx:	Normal	Abnormal
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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

Comment: decreased ROM due to pain in lumbar spine and right hip.

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

Asked pt what they smelled, asked pt to read off their medications, blinking of eyes, performed fields of gaze, asked pt to clinch teeth, shrug shoulders, swallow, stick out their tongue, smile, and move neck and extremities through ROM, asked patient to stand up, take a couple of steps forwards, backwards, and to sit back down.

Indicate cranial nerve deficits found

NO cranial nerve deficit noted.

Romberg Test	Normal	Abnormal
Examination of reflexes:	Normal	Abnormal
Examination of sensation:	Normal	Abnormal

Coordination:	Normal	Abnormal
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Diabetes

Foot Exam:	Normal	Abnormal
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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	Diagnosis	Comments
DIGITAL_RETINAL_EXAM	No	Select			Select				
HBA1C	No	Select			Select				
MICROALBUMIN	No	Select			Select				
FOBT	Yes	Mail Kit Direct to member			No				Unable to perform due to virtual visit.
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 : 6

Person's Answers: Mother, Daughter

Word Recall :	1 Points	1 point for each word spontaneously recalled without cueing. Home Safety Yes
Clock Draw :	2 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 :	3 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?

Wish I was younger

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

comments

When I was a child and they are not able to harm me now. It was her father.

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 :

This is a completed audio & video virtual visit. Verbal consent was received by the patient to conduct this virtual visit. Patient identity was verified by address and DOB. Palpation, percussion, and auscultation portions of the assessment were unable to be performed due to this being a virtual visit. Unable to obtain complete set of VS, during HRA visit, due to virtual visit.

The patient's phone died and I called and left a message for her to dry and reconnect at another time and finish her call. (7/24/2021 8:40am). Was able to reconnect with patient and finish her visit. Patient had an elevated PHQ9 score. Currently she has her mother living in the house with her and she is going through hospice care. This has proven to be really difficult for her to handle both physically and emotionally. Discussed that she needs to contact Dr. Snow and let him know what she is going through in order to assist with her medication regimen. She may need counseling so that can better care for herself during this time. Will send referral.

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 :	2021-07-24T08:25
Time exam finished	2021-07-24T09:12
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Consented to Video chat	<input checked="" type="checkbox"/>
Provider Signature	<div> <div> Candace Hembrick </div> <div>  Digitally signed by Candace Hembrick , FNP 2021-07-24, 23:55 </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?