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|----------------|--------------|-----------|----------------------|
| Name | : JUDY S LEE | Age | : 67 |
| Date of Birth | : 1953-07-21 | Member ID | : 11005869 |
| Evaluator Name | : | Date | : 2021-03-07T12:10 |
| Gender | : Female | Address | : 1009 ALVIEW AVE NW |
| Lob | : DSNP | | |

Your Vital Signs

| | | | | | |
|----------------|-------------------------------|-----------------|---------------|------------------|---------|
| Blood Pressure | 188/102 mmHG | Pulse | 92 bpm | Respiratory Rate | 12 |
| Temp | 98.1 | Pulse Oximetry | 95 | Pain Scale /10 | 0 |
| Age | 67 | Patients Height | 5 feet 6 inch | Patients Weight | 140 lbs |
| BMI | 22.6(Obesity (BMI 30 – 34.9)) | | | | |

Your Screenings

| Screening Name | Screening Completed | Exam Date | Screening Result | Diagnosis | Comments |
|----------------------|---------------------|-----------|------------------|--------------|----------|
| DIGITAL_RETINAL_EXAM | Select | | | | |
| HBA1C | Select | | | | |
| MICROALBUMIN | Select | | | | |
| FOBT | Select | | | r/o bleeding | |
| DEXA | Select | | | | |
| PAD | Select | | | | |
| Peak Flow Meter | Select | | | | |

Allergies

Answer: No

Your Medications

| Dose Date | Label Name | Dose / Units | Route | Frequency | Status |
|------------|-------------------------------|--------------|---------------|-----------|--------|
| 2021-03-07 | Oxcarbazepine liq 300 mg/5 ml | 10 ml | PO = By Mouth | BID | |
| 2021-03-07 | Levetiracetam liq 100 mg/ml | 5 ml | PO = By Mouth | BID | |

Over the Counter Medications / Supplements

Answer: No

1. Race

Answer: African American

Diagnoses under Chronic Care Management

| | | | |
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Active

Difficulty with vision

Legally Blind : **No**

Difficulty with Hearing

Other, Supported By History, Symptoms

Other : **Has had teeth pulled, implants**

Cerebral Palsy, Supported By History

Seizure Disorder, Supported By History of recurrent seizures, Medications

Osteoarthritis, Supported By Symptoms

Which joints : **Right knee pain**

History Of

Anemia, Supported By Other

Describe : **Medical record**

Etiology :

If yes, Patient on :

Care management related to self - assessment and psychosocial behaviors

- Based on score of initial screen, cognitive function is questionable, refer to Neurology for further assessment.

Mini cog : **0**

- Further assessment and questioning should be done to determine if patient's literacy level is adequate, limited or poor to determine the best method to communicate instructions and information to the patient.

When you get written information at a doctor's office would you say it is? : **Somewhat difficult**

When you read the instructions on a prescription bottle would you say that it is? : **Somewhat difficult**

How confident are you in filling out medical forms by yourself? : **Not at All Confident**

- Counsel patient on the need for an Advance Directive.

Do you have an Advance Directive? : **No**

- Further assessment is required with a GAD 7 and or referral for a psychological evaluation

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

Care management related to patient's activity levels

Care management related to preventive care

| Screen | Answer |
|-------------------------|--------|
| Colonoscopy | No |
| Breast Exam/Mammography | Yes |
| Cervical Screening | No |
| Bone Density | No |

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| | |
|----------------------------|----------------|
| 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 | Don't Know |

Care management related to diagnoses and symptoms

- Are you currently seeing any specialists?

Answer: Yes

| Family Member | Medical Condition | Cause of Death |
|---------------|--------------------|----------------|
| Father | Cancer | |
| Mother | CAD, DM | |
| Sibling1 | Mult siblings w/DM | |

Home Safety and Personal Goals

- Patient should be referred to Occupational Therapy for a home safety check

- Do you have obstacles in the house, loose small rugs or objects on the floor that could cause tripping? : No
- Do you have electrical cords running across floors, in doorways or under a rugs? : No
- Do you have no slip mats on the shower floor or bath tub? : Yes
- Do have adequate lighting in hallways and on the stairs? : Yes
- Do you have handrails on staircases? : Yes
- Is your hot water heater set for a maximum of 120 degrees? : Yes
- Do you have smoke detectors on each level of the house and in all sleeping a rooms? : Yes
- Do you have carbon Monoxide detectors on each level of the house? : Yes
- Have used established an escape route in the event of fire? : Yes

Are there things about yourself you wish you could change or improve?

Answer: Would like to work

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

Answer: Being able to get out more