

CONFIDENTIAL INFORMATION

From :

c/o Focus Care
500 West Cummings Park
Suite 2700
Woburn, MA 01801

To :

FARTASH, SIMA
2200 Opitz Blvd Ste 235
221913343

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c/o Focus Care
500 West Cummings Park
Suite 2700
Woburn, MA 01801

FARTASH, SIMA
2200 Opitz Blvd Ste 235
Woodbridge

FARTASH, SIMA

Through our partnership with Focus Care, your patient, covered through Virginia Premier Health, recently received a health visit by one of Focus Care's clinicians. Enclosed is a summary of the visit results for:

MARIA F MARTINEZ
1953-08-06
11009250

This summary contains an environmental assessment, a summary of existing diagnoses, a list of current medications that may help you gain additional insight into your patient's health, as well as preventive and chronic care recommendations. Please discuss the findings with your patient at their next appointment or reach out to them for urgent concern.

Sincerely,

Thomas Lundquist, M.D.
Chief Medical Officer
Virginia Premier Health

Patient Assessment Summary

| | | | |
|----------------|--------------------|----------------|-----------------------------------|
| Name | : MARIA F MARTINEZ | Age | : 67 |
| Date of Birth | : 1953-08-06 | Member ID | : 11009250 |
| Evaluator Name | : undefined | Date | : undefined |
| Gender | : Female | Address | : 13210 STAGGS CT, WOODBRIDGE, VA |
| Lob | : DSNP | Marital Status | : Single |
| Email | : | Phno | : 7034748188, |

Your Vital Signs

| | | | | | |
|----------------|-------------|-----------------|----|------------------|-----|
| Blood Pressure | 124/86 mmHG | Pulse | 99 | Respiratory Rate | 16 |
| Temp | 97.7 | Pulse Oximetry | 95 | Pain Scale /10 | 0 |
| Age | 67 | Patients Height | 5 | Patients Weight | 176 |
| BMI | 34.4 | | | | |

Your Screenings

| Screening Name | Screening Completed | Exam Date | Screening Result | Diagnosis | Comments |
|----------------------|---------------------|-----------|------------------|----------------------------------|--|
| DIGITAL_RETINAL_EXAM | Select | | | | |
| HBA1C | Select | | | | |
| MICROALBUMIN | Select | | | | |
| FOBT | Select | | | screening for fecal occult blood | reviewed instructions with member, member verbalized understanding |
| DEXA | Select | | | | |
| PAD | Select | | | | |
| Peak Flow Meter | Select | | | | |

Allergies

Answer: No

Your Medications

| Diagnoses | Label Name | Dose / Units | Route | Frequency | Prescribing Physician | Status |
|----------------------|--------------|--------------|---------------|-----------|-----------------------|------------|
| HTN | AMLODIPINE | TAB 10MG | PO = By Mouth | QD | Fartash | Taking |
| HLD | ATORVASTATIN | TAB 40MG | PO = By Mouth | QD | Fartash | Taking |
| | TERBINAFINE | TAB 250MG | Select | Select | | Not Taking |
| | CICLOPIROX | SOL 0.08 | Select | Select | | Not Taking |
| | CLOTRIM/BETA | CRE DIPROP | Select | Select | | Not Taking |
| | KETOCONAZOLE | CRE 0.02 | Select | Select | | Not Taking |
| HTN | losartan | 25 mg | PO = By Mouth | QD | Fartash | Taking |
| Vitamin D deficiency | vitamin D3 | 50,000 iu | PO = By Mouth | QW | Fartash | Taking |

Over the Counter Medications / Supplements

Patient Assessment Summary

| | | | |
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Answer: **No**

Race

Answer: **Latino**

Preferred language

Answer: **Other**

If other,

Answer: Spanish

Diagnoses under Chronic Care Management

Active

Hyperlipidemia

Is patient on Statin **Yes**

Hypertension

Adequately controlled **Yes**

Other

Other

Other

Other

Care management related to self - assessment and psychosocial behaviors

Limited English proficiency, may require the use of a translator and or written information provided in preferred language.

Preferred Language **Other**

Comment :

If other,

Comment

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.

How much school have you completed? **Completed 3rd grade**

Comment :

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

Comment :

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

Comment :

How confident are you in filling out medical forms by yourself? **Not Very Confident**

Comment :

Social service referral to further assess social support infrastructure

Do you have someone who can help if you are sick or have problems? **Yes**

Comment : **children and spouse**

Counsel patient on the need for a Healthcare Proxy.

Do you have a Healthcare Proxy? **No**

Comment :

Counsel patient on the need for a Durable Power of Attorney.

Patient Assessment Summary

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| Lob | : DSNP | Marital Status | : Single |
| Email | : | Phno | : 7034748188, |

Do you have a Durable Power of Attorney? **No**

Comment :

Counsel patient on the need for an Advance Directive.

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

Comment :

Care management related to patient's activity levels

- Patient should be referred for a physical therapy evaluation related to ADL's.

Refer patient for a physical therapy evaluation

A. Getting in or out of bed : **No**

Refer patient for a physical therapy evaluation related to ADL's

B. Getting in or out of chairs : **No**

C. Toileting : **No**

D. Bathing : **No**

E. Dressing : **No**

F. Eating : **No**

G. Walking : **No**

H. Going up or down stairs : **No**

Care management related to past medical history

Do you use any assistive devices? (Check device or none if no devices used)

Answer: None

Comment:

Are you currently seeing any specialists?

Answer: **Yes**

| Medical Specialty | Specialist | For |
|-------------------|--------------|------------------|
| Ophthalmologist | unknown name | routine eye exam |
| Podiatrist | unknown name | bunion |

If no activities are checked as need some help or total help

Refer patient for a physical therapy evaluation : **4**

A. Seen your PCP

Refer patient for a physical therapy evaluation related to ADL's

B. Visited the Emergency Room : **None**

C. Stayed in the hospital overnight : **None**

D. Been in a nursing home : **None**

E. Had Surgery : **None**

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

Answer: **No**

- In the past year how many times have you Fallen?

Answer: **None**

Social service referral to evaluate history of potential abuse

- Have you ever physically or felt emotionally abused by someone

Answer: **No**

Have you lost weight in the past 6 months?

Answer: **None**

Care management related to preventive care

Counsel patient on screening guidelines with relation to type of screens that are age and gender appropriate and timelines for those screens going forward.

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

Care management related to diagnoses and symptoms

Family History

Answer: **Yes**

| Family Member | Medical Condition | Cause of Death |
|---------------|-------------------|----------------|
| Mother | HTN, HLD | 75 - MI |
| Father | | 81 - stroke |

- In the past year how many times have you Fallen?

Answer: **None**

Assessors Comments :

Member pleasant, Spanish speaking, lives at home with spouse. Member stated she does not have diabetes and states her doctor told her at her last visit she was "doing well." Reviewed medications with member who verbalized understanding of each medication. Discussed importance of exercise and regular f/u with pcp. Left FIT test with member, reviewed instructions with member in detail. Member verbalized understanding