

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	LONNIE L MEREDITH
Evaluator Name :	
Assessment Type :	Health Risk Assessment
DOB :	1950-07-06
Evaluation Date :	
Visit Type :	Virtual: Video & Audio Capability

Demographics

Plan	VPHP
Program	MEDICARE
LOB	DSNP
Name	LONNIE L MEREDITH
Gender	Male
Address	953 4TH ST NE
City	PULASKI
State	VA
Zip	24301-5209
Date of Birth	1950-07-06
Age(as of date)	71
Marital Status	
Member Identification Number	11000263
HICN	
Phone Number	5406413139
Cell Number	
Alternate Contact Number	
Email	
Emergency Contact	
Phone Number	
Primary Care Physician	MORGAN, BENJAMIN H
Phone Number	
PCP Address	701 Randolph St Ste 120
PCP City	Radford
PCP State	VA

PCP Zip	241413047
PCP County	
Office ID	
Office Name	CARILION FAMILY MEDICINE RADFORD

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

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

How much school have you completed?

- ☐ Completed less than 3rd grade
- ☐ Completed less than 8th grade
- ☐ Completed less than 12th grade
- ☐ Completed 12th grade, or attended College

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

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

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

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

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

- ☐ Not at All Confident ☐ Not Very Confident ☐ Confident
☐ Very Confident

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

- ☐ Excellent ☐ Good ☐ Fair
☐ Poor

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

Where do you currently live?

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

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

- ☐ Yes ☐ No

Who do you currently live with?

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

Are you currently a caregiver for someone?

- ☐ Yes ☐ No

Are you currently employed?

- ☐ Yes ☐ No

Are you interested in employment?

- ☐ Yes ☐ No

Do you volunteer currently?

- ☐ Yes ☐ No

Tobacco use

- ☐ Current ☐ Former ☐ Never

Alcohol Use

- ☐ Current ☐ Former ☐ Never

Do you or have you used recreational drugs?
☐ Yes ☐ No

Do you have a Healthcare Proxy?
☐ Yes ☐ No ☐ Don't Know

Do you have a Durable Power of Attorney?
☐ Yes ☐ No ☐ Don't Know

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

- Recommendations
- ☐ Smoking/Tobacco
 - ☐ Substance Abuse
 - ☐ Durable Power of attorney
 - ☐ Healthcare Proxy
 - ☐ Advanced Directive
 - ☐ Food Disparity
 - ☐ Literacy
 - ☐ Social support evaluation

Activities of Daily Living

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

Do you use any assistive devices or DME?
☐ None ☐ Cane ☐ Walker ☐ Prosthesis

- ☐ Oxygen
☐ Urinal
☐ Other
- ☐ Wheel Chair
☐ Bed Pan
- ☐ Bedside Commode
☐ CPAP

Are you currently seeing any specialists?

- ☐ Yes
- ☐ No

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

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

- ☐ Yes
- ☐ No

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
Adult Day Care	Yes	No

In the past year 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

Family History

☐ Yes

☐ No

Preventive Care

In the past three years have you had?

Screen	Answer	Date	Method	Recommendation	Education Completed
Breast Cancer Screening				<input type="checkbox"/>	<input type="checkbox"/>
Colorectal Screening				<input type="checkbox"/>	<input type="checkbox"/>
Influenza Vaccine			N/A	<input type="checkbox"/>	<input type="checkbox"/>
COVID-19 Vaccine			N/A	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal Vaccine			N/A	<input type="checkbox"/>	<input type="checkbox"/>
Herpes Zoster Vaccine			N/A	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Screening			N/A	<input type="checkbox"/>	<input type="checkbox"/>
Diabetic Foot Exam			N/A	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol Screening			N/A	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma Screening			N/A	<input type="checkbox"/>	<input type="checkbox"/>
STIs/HIV Screening			N/A	<input type="checkbox"/>	<input type="checkbox"/>
Cervical Cancer Screening			N/A	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis Screening				<input type="checkbox"/>	<input type="checkbox"/>
Prostate Screening			N/A	<input type="checkbox"/>	<input type="checkbox"/>
Fall Risk Screening			N/A	<input type="checkbox"/>	<input type="checkbox"/>

One time screen for Abdominal Aortic Aneurysm if male with history of smoking, age 65 - 75

☐ Yes

☐ No

☐ NA

One time screen for Hepatitis C if born between 1945 - 1965

☐ Yes

☐ No

☐ NA

Recommendations

- ☐ Abdominal Aneurysm Screening
- ☐ Hepatitis C Screening

Allergies / Medications

35. Allergies

☐ Yes ☐ No

Medications

Diagnoses	Label Name	Dose / Units	Route	Frequency	Prescribing Physician	Status
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36. Over the Counter Medications / Supplements

☐ Yes ☐ No

Long Term Use of:

☐ None

☐ ASA ☐ Steroids ☐ Insulin
☐ Anticoagulants ☐ Statins ☐ Biphosphonate

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

Recommendations

- ☐ Discuss options with your Doctor and/or pharmacist to improve medication adherence
- ☐ Discuss medication side effects with your Doctor
- ☐ Other
- ☐ Educated on importance of medication compliance, member verbalizes understanding

Review of Systems and Diagnoses

Eye Problems (Glaucoma, Cataracts, Macular Degeneration, Blindness, Retinal Detachment, Other)

☐ 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

Recommendations

- ☐ Hearing evaluation
- ☐ Dental exam
- ☐ Eye exam
- ☐ Swallowing evaluation
- ☐ Take medications as prescribed
- ☐ Other

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

☐ Yes

☐ No

Recommendations

- ☐ Take medications as prescribed
- ☐ Other

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

☐ Yes

☐ No

Recommendations

- ☐ Blood Pressure checks
- ☐ Heart Healthy Diet
- ☐ Exercise 30 min a day
- ☐ Take medications as prescribed
- ☐ Other

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

☐ Yes

☐ No

Recommendations

- ☐ Take medications as prescribed
- ☐ Other

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

☐ Anxiety

☐ Cerebral Hemorrhage

☐ Delusional Disease

☐ Depression

☐ Fibromyalgia

☐ Hemiparesis

☐ Insomnia

☐ Migraine Headaches

☐ Muscular Dystrophy

☐ Parkinson's disease

☐ Restless leg syndrome

☐ Seizures

☐ Stroke

☐ TIA

☐ Other
- ☐ Amyotrophic Lateral Sclerosis

☐ Bipolar Disorder

☐ Cerebral Palsy

☐ Dementia

☐ Drug Dependence

☐ Guillain-Barre Disease

☐ Huntington's Chorea

☐ Intellectual and or Developmental Disability

☐ Multiple Sclerosis

☐ Myasthenia Gravis

☐ Peripheral Neuropathy

☐ Schizophrenia

☐ Spinal Cord Injury

☐ Subdural Hematoma

☐ Traumatic Brain Injury

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 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 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
- ☐ 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

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)

- ☐ Intention Tremor
- ☐ Tremor)
- ☐ Non-Intention (Pill rolling) Tremor
- ☐ Rigidity
- ☐ Spasticity
- ☐ Chorea Movement
- ☐ Cog wheeling
- ☐ Normal

Gait

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

Recommendations

- ☐ Take medications as prescribed
- ☐ Other

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

- ☒ Yes
- ☐ No

Diagnoses

- ☐ Acute Renal Failure

☐ BPH
- ☐ Chronic Kidney Disease

☐ ESRD
- ☐ Erectile Dysfunction

☒ Frequent UTI
- ☒ Gynecological

☒ Kidney Stones
- ☒ Nephritis or Nephrosis

☒ Urinary Incontinence
- ☒ Other
- Frequent UTI

☐ Describe

☐ Active

☐ History of

☐ Rule out

☐ Supported by

☐ Symptoms

☐ Cultures

☐ Laboratory results

☐ Other
- Gynecological

☐ Describe

☐ Active

☐ History of

☐ Rule out

☐ Supported by

☐ Symptoms

☐ History

☐ Diagnostic results

☐ Medications

☐ Vaginal Bleeding

☐ Other
- Kidney Stones

☐ Describe

☐ Active

☐ History of

☐ Rule out

☐ Supported by

☐ History

☐ Symptoms

☐ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Other
- Type

☐ Urate

☐ Calcium Oxalate

☐ Magnesium

Other

Nephritis or Nephrosis

Describe

Active

Supported by

Medical history

Biopsy

Urinary Incontinence

Describe

Active

Supported by

History

Medications

Other

Related to stress

Yes

Describe

Daily

Other

Describe

Active

Supported by

History

Medications

Biopsy

Other

History of

Lab tests

Medications

History of

Symptoms

Test results

No

Few times a week

History of

Symptoms

Test results

DME

Rule out

Imaging studies

Other

Rule out

Physical Findings

DME

Less than once a week

Rule out

Physical Findings

Image studies

Other

Recommendations

Take medications as prescribed

Other

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

Yes

No

Diagnoses

Collagen (Connective) Tissue Disease

Extremity Fracture

Hallux Valgus

Osteoarthritis

Osteoporosis

Rheumatoid Arthritis

Systemic Lupus Erythematosus

Collagen (Connective) Tissue Disease

Describe

Active

Supported by

Degenerative Disc Disease

Gout

Hammer Toes

Osteomyelitis

Pyogenic Arthritis

Spinal Stenosis

Other

History of

Rule out

- ☐ Physical Findings

☐ Image studies

☐ Lab tests

☐ Other

☐ Biopsy
- Describe

☐ SLE(Lupus)

☐ Scleroderma

☐ Dermatomyositis
- Degenerative Disc Disease

Describe

☐ Active

☐ History of

☐ Rule out

Supported by

☐ Symptoms

☐ Physical Findings

☐ Image studies

☐ Medications

☐ Other

Normal bladder and bowel function

☐ Yes

☐ No

Site of disease

☐ Cervical

☐ Thoracic

☐ Lumbar

☐ Lumbosacral

☐ Other

Extremity Fracture

Describe

☐ Active

☐ History of

☐ Rule out

Supported by

☐ History

☐ Symptoms

☐ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Extremity

☐ Shoulder

☐ Arm

☐ Forearm

☐ Wrist

☐ Hand

☐ Femoral Shaft

☐ Tibia

☐ Fibula

☐ Ankle

☐ Foot

☐ Hip

Current (within 12 weeks)

☐ Yes

☐ No

Gout

Describe

☐ Active

☐ History of

☐ Rule out

Supported by

☐ History of attacks in

☐ Lab tests

☐ Medications

☐ Foot

☐ Other

Hallux Valgus

Describe

☐ Active

☐ History of

☐ Rule out

Supported by

☐ History

☐ Symptoms

☐ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

Hammer Toes


Describe

☐ Active

☐ History of

☐ Rule out

Supported by

 FOCUSCARE

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<input type="checkbox"/> History	<input type="checkbox"/> Symptoms	<input type="checkbox"/> Physical Findings
<input type="checkbox"/> Medications	<input type="checkbox"/> Test results	<input type="checkbox"/> Image studies
<input type="checkbox"/> Biopsy	<input type="checkbox"/> DME	<input type="checkbox"/> Other
Osteoarthritis		
<input type="checkbox"/> Describe		
<input type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
<input type="checkbox"/> Supported by		
<input type="checkbox"/> Symptoms	<input type="checkbox"/> Physical Findings	<input type="checkbox"/> Image studies
<input type="checkbox"/> Other		
<input type="checkbox"/> Which joints		
Osteomyelitis		
<input type="checkbox"/> Describe		
<input type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
<input type="checkbox"/> Supported by		
<input type="checkbox"/> Hospitalization	<input type="checkbox"/> Image studies	<input type="checkbox"/> Cultures
<input type="checkbox"/> Medications	<input type="checkbox"/> Other	
Osteoporosis		
<input type="checkbox"/> Describe		
<input type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
<input type="checkbox"/> Supported by		
<input type="checkbox"/> DEXA scan	<input type="checkbox"/> Medications	<input type="checkbox"/> Imaging studies
<input type="checkbox"/> Symptoms	<input type="checkbox"/> Fracture history	<input type="checkbox"/> Other
Pyogenic Arthritis		
<input type="checkbox"/> Describe		
<input type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
<input type="checkbox"/> Supported by		
<input type="checkbox"/> Hospitalization	<input type="checkbox"/> Image studies	<input type="checkbox"/> Cultures
<input type="checkbox"/> Medications	<input type="checkbox"/> Other	
<input type="checkbox"/> Which joint/s		
Rheumatoid Arthritis		
<input type="checkbox"/> Describe		
<input type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
<input type="checkbox"/> Supported by		
<input type="checkbox"/> Symptoms	<input type="checkbox"/> Physical findings	<input type="checkbox"/> Medications
<input type="checkbox"/> Lab tests	<input type="checkbox"/> Image Studies	<input type="checkbox"/> Other
<input type="checkbox"/> Which joints		
Spinal Stenosis		
<input type="checkbox"/> Describe		
<input type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
<input type="checkbox"/> Supported by		
<input type="checkbox"/> Symptoms	<input type="checkbox"/> Physical Findings	<input type="checkbox"/> Image studies
<input type="checkbox"/> Medications	<input type="checkbox"/> Other	
<input type="checkbox"/> Normal bladder and bowel function		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Systemic Lupus Erythematosus		
<input type="checkbox"/> Describe		
<input type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out

↳ Supported by

☐ Labs

☐ other

Other

↳ Describe

☐ Active

↳ Supported by

☐ History

☐ Medications

☐ Biopsy

Other

☐ Medications

☐ History of

☐ Symptoms

☐ Test results

☐ DME

☐ History

☐ Rule out

☐ Physical Findings

☐ Image studies

☐ Other

Have you had an amputation?

☐ Yes

☐ No

Recommendations

☐ Discuss PT/OT evaluation with PCP

☐ Take medications as prescribed

☐ Other

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

☒ Yes

☐ No

↳ Diagnoses

☒ Basil Cell Carcinoma

☒ Eczema

☒ Psoriasis

☒ Tinea Pedis

☒ Wound

☒ Dermatitis

☒ Onychomycosis

☒ Skin ulcer

☒ Urticarial Disease

☒ Other

Basil Cell Carcinoma

↳ Describe

☐ Active

↳ Supported by

☐ History

☐ Medications

☐ Biopsy

☐ History of

☐ Rule out

☐ Symptoms

☐ Test results

☐ DME

☐ Physical Findings

☐ Image studies

☐ Other

Dermatitis

↳ Describe

☐ Active

↳ Supported by

☐ History

☐ Medications

☐ Biopsy

↳ What type

☐ Contact

☐ Disease Induced

☐ History of

☐ Rule out

☐ Symptoms

☐ Test results

☐ DME

☐ Physical Findings

☐ Image studies

☐ Other

☐ Stasis

☐ Unspecified

☐ Drug induced

Eczema

↳ Describe

☐ Active

↳ Supported by

☐ History of

☐ Rule out



FOCUSCARE

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

Other

Describe

Active

History of

Rule out

Supported by

History

Symptoms

Physical Findings

Medications

Test results

Image studies

Biopsy

DME

Other

Other

Recommendations

Take medications as prescribed

Other

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

Peripheral Neuropathy secondary to Diabetes

Peripheral Vascular Disease secondary to Diabetes

Hyperparathyroidism

Other

Chronic Kidney Disease secondary to Diabetes

Describe

Active

History of

Rule out

Supported by

Decreased GFR

Albuminuria

Elevated BUN/ Creatinine

Dialysis

Other

Patient on ACE or ARB

Yes

No

Coronary Artery Disease and Diabetes

Describe

Active

History of

Rule out

Supported by

☐ History

☐ Medications

☐ Biopsy

☐ Symptoms

☐ Test results

☐ DME

☐ Physical Findings

☐ Image studies

☐ Other

Is patient on a statin

☐ Yes

☐ No

Is patient on an aspirin

☐ Yes

☐ No

Cushing's Disease

Describe

☐ Active

☐ History of

☐ Rule out

Supported by

☐ Physical exam

☐ Lab tests

☐ Suppression Test

☐ Other

Diabetes

Describe

☐ Active

☐ History of

☐ Rule out

Supported by

☒ Symptoms

☐ Physical findings

☐ Lab tests

☐ Medications

☐ Other

Type

☐ Type 1

☐ Type 1.5

☐ Type 2

☐ Gestational

Most recent Hb A1C, value

And Date

Met with a nurse or dietician for diabetic education

☐ Yes

☐ No

Met with a diabetic educator

☒ Yes

☐ No

Do you test your blood sugar

☒ Yes

☐ No

Diabetic Retinopathy

Describe

☐ Active

☐ History of

☐ Rule out

Type

☐ Proliferative

☐ Non-proliferative

☐ Unknown

Specify

☐ Right eye

☐ Left eye

☐ Bilateral

Supported by

☐ Funduscopy exam

☐ Vision loss

☐ Laser Therapy

☐ Retinal Injections

☐ Surgical procedure

☐ Other

Patient sees Ophthalmologist

☐ Occasionally

☐ Once a year

☐ Twice a year

☐ >Twice a year

Secondary Hyperparathyroidism

Describe

☐ Active

☐ History of

☐ Rule out

Supported by

☐ History Chronic Kidney Disease

☐ Malabsorption

☐ History of kidney stones

☐ Fatigue

Due to kidney disease?

☐ Yes

Hypertension and Diabetes

Describe

☐ Active

Supported by

☐ History

☐ Medications

☐ Biopsy

Is patient on Ace or ARB

☐ Yes

Hyperthyroidism

Describe

☐ Active

Supported by

☐ Rapid Heart Beat

☐ Heat Intolerance

☐ History of treatment for Hyperthyroidism

Hypothyroidism

Describe

☐ Active

Supported by

☐ Weight gain

☐ Depression

☐ Other

Peripheral Neuropathy secondary to Diabetes

Describe

☐ Active

Supported by

☐ Physical exam

☐ Other

Patient sees Podiatrist

☐ Yes

☐ No

Peripheral Vascular Disease secondary to Diabetes

Describe

☐ Active

Supported by

☐ Physical exam

☐ Foot deformity

☐ History Vitamin D Deficiency

☐ Bariatric Surgery

☐ History of Fractures

☐ Other

☐ History Celiac Disease

☐ Lab tests

☐ Imaging studies

☐ History of

☐ Symptoms

☐ Test results

☐ DME

☐ Rule out

☐ Physical Findings

☐ Image studies

☐ Other

☐ History of

☐ Nervousness

☐ Tremor

☐ Hyper Reflexes

☐ Rule out

☐ Weight Loss

☐ Lab Data

☐ Other

☐ History of

☐ Fatigue

☐ Treatment for hypothyroidism

☐ Rule out

☐ Hair changes

☐ Lab data

☐ History of

☐ Medication

☐ Rule out

☐ Symptoms

☐ History of

☐ Vascular studies

☐ Surgical procedures

☐ Rule out

☐ Skin lesions

☐ Intermittent

claudication

☐ Other

↳ Patient sees Podiatrist

☐ Yes

☐ No

Hyperparathyroidism

↳ Describe

☐ Active

☐ History of

☐ Rule out

↳ Supported by

☐ Lab tests

☐ History of kidney stones

☐ History of Fractures

☐ Imaging studies

☐ Fatigue

☐ Other

Other

↳ Describe

☐ Active

☐ History of

☐ Rule out

↳ Supported by

☐ History

☐ Symptoms

☐ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☐ Biopsy

☐ DME

☐ Other

↳ Other

Recommendations

- ☐ Take medications as prescribed
- ☐ Check Blood sugar
- ☐ Other

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

- ☒ Yes
- ☐ No

↳ Diagnoses

☒ AIDS

☒ Anemia

☒ C. Difficile

☒ Community Acquired MRSA Infection

☒ HIV

☒ Herpes Zoster

☒ Hospital Acquired MRSA Infection

☒ Immune Deficiency

☒ Sepsis

☒ Sickle Cell Disease

☒ Sickle Cell Trait

☒ Thalassemia

☒ Thrombocytopenia

☒ Tuberculosis

☒ Vitamin D Deficiency

☒ Other

AIDS

↳ Describe

☐ Active

☐ History of

☐ Rule out

↳ Supported by

☐ Symptoms

☐ Physical findings

☐ History of opportunistic infections

☐ Medications

☐ Other

↳ Is patient currently under treatment

☐ Yes

☐ No

Anemia

- Describe

Active

History of

Rule out
- Supported by

Lab tests

Symptoms

History of blood transfusion

Other
- Etiology

Iron deficiency

Pernicious

Kidney disease

Hemolysis

Aplastic

Chemotherapy

Blood loss

Chronic Disease

Folate Deficiency

Other
- If yes, Patient on

Iron

B 12

Folic Acid

Blood Transfusions

Other

C. Difficile

- Describe

Active

History of

Rule out
- Supported by

Positive lab test

Symptoms

Hospitalization

Medication

Other

Community Acquired MRSA Infection

- Describe

Active

History of

Rule out
- Supported by

Cultures

Hospitalization

Medications

Physical findings

Other

HIV

- Describe

Active

History of

Rule out
- Supported by

Lab tests

Symptoms

Medications

Other
- Viral load
- C4
- Patient currently symptomatic

Yes

No
- Is patient currently under active treatment

Yes

No

Herpes Zoster

- Describe

Active

History of

Rule out
- Supported by

Rash

Symptoms

Medications

Other

Hospital Acquired MRSA Infection

- Describe

<ul style="list-style-type: none"> <ul style="list-style-type: none"> Active 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> History of 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Rule out
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Supported by <ul style="list-style-type: none"> Cultures Physical findings 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Hospitalization Other 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Medications
Immune Deficiency		
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Describe <ul style="list-style-type: none"> Active 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> History of 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Rule out
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Supported by <ul style="list-style-type: none"> History Medications Other 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Symptoms Test results 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Physical Findings Image studies
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Etiology 		
<ul style="list-style-type: none"> <ul style="list-style-type: none"> History of Opportunistic Infection <ul style="list-style-type: none"> Yes No 		
Sepsis		
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Describe <ul style="list-style-type: none"> Active 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> History of 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Rule out
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Supported by <ul style="list-style-type: none"> Blood Cultures Hospitalization 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Other cultures Unstable vital signs 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Symptoms Other
Sickle Cell Disease		
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Describe <ul style="list-style-type: none"> Active 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> History of 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Rule out
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Supported by <ul style="list-style-type: none"> Family history Hospitalizations 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Symptoms Other 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> History of infections
Sickle Cell Trait		
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Describe <ul style="list-style-type: none"> Active 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> History of 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Rule out
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Supported by <ul style="list-style-type: none"> Family history 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Lab test 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Other
Thalassemia		
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Describe <ul style="list-style-type: none"> Active 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> History of 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Rule out
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Supported by <ul style="list-style-type: none"> Family history History of infections 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Symptoms Other 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Lab tests
Thrombocytopenia		
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Describe <ul style="list-style-type: none"> Active 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> History of 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Rule out
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Supported by <ul style="list-style-type: none"> Lab tests Other 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> Physical findings 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> History
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Etiology 		
Tuberculosis		
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Describe <ul style="list-style-type: none"> Active 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> History of active TB 	<ul style="list-style-type: none"> <ul style="list-style-type: none"> TB Infection

☐ Bladder

☐ Prostate

☐ Lymph Nodes

☐ Ovaries

☐ Bone

☐ Skin

☐ Uterus

☐ Blood

☐ Other

Specific type/s

Stage or Classification specific to the cancer

Active treatment

☒ Yes

☐ No

Active treatment

☐ Chemotherapy

☐ Bone Marrow

☐ Other

☐ Radiation

☐ Surgery

☐ Stem Cell

☐ Immune System

Side effects

☐ Nausea

☐ Anemia

☐ Weakness

☐ Vomiting

☐ Neutropenia

☐ Loss of appetite

☐ Diarrhea

☐ Thrombocytopenia

☐ Other

Is there a current finding of Metastasis?

☒ Yes

☐ No

Location

History / finding of Cachexia

☒ Yes

☐ No

Do you see a specialist?

☒ Yes

☐ No

Provider

Recommendations

☐ Take medications as prescribed

☐ Other

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

Rate your pain on a scale of 1-10, with 1 being very mild and 10 being severe

Frequency of pain

☒ Occasional

☐ One or more times a week

☐ All of the time

Is the Patient Undergoing Pain Management Planning?

☐ Yes ☐ No

Is the member taking a narcotic or Opioid Medication?

☒ Yes ☐ No

↳ What drugs do you take for it?

↳ 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

Was the patient advised regarding the potential for dependence?

☐ 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	BMI
(Feet)	(Inch)	(lbs)	

☐ Obesity ☐ Moderate Obesity ☐ Morbid Obesity

☒ **Malnutrition**

↳ Describe

☐ Active ☐ History of ☐ Rule out

↳ Malnutrition

☐ Yes ☐ No

↳ Supported by

☐ Albumin < 3.5 g/dl ☐ Muscle wasting ☐ History of severe weight loss

Are you on a special diet?

☐ Heart Healthy Diet ☐ Diabetic Diet ☐ Renal Diet

- ☐ Vegetarian
- ☐ Keto

- ☐ Vegan
- ☐ Pescatarian

- ☐ Gluten Free
- ☐ Other

Have you lost weight in the past 6 months?

- ☐ None
- ☐ 5lbs
- ☐ 15lbs
- ☐ More than 15lbs

- ☐ 10lbs
- ☐ 10% of your weight
(calculated by assessor)

Recommendations

- ☐ Nutrition/ weight management
- ☐ Other

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
Auscultation of lungs:	Normal	Abnormal

Cardiovascular

Auscultation of heart:	Normal	Abnormal
Palpation and auscultation of Carotid Arteries:	Normal	Abnormal
Pedal Pulses:	Normal	Abnormal
Examination of Edema / Varicosities:	Normal	Abnormal
Examination of Radial Pulses:	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
---	--------	----------

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

MICROALBUMIN

☒ Yes

☐ No

↳ Status options

☒ Member refused

☐ Left kit

☐ Collected Sample

☐ Mail Kit direct to member

↳ Reason member refused

☐ Member recently completed

☐ Scheduled to complete

☐ Member apprehension

☐ Not interested

☐ Other

↳ Microalbumin Test Barcode

↳ Exam Date

↳ Screening Result

↳ Diagnosis

↳ Comments

FOBT

☒ Yes

☐ No

↳ Status options

☒ Member refused

☐ Left kit

☐ Collected Sample

☐ Mail Kit direct to member

↳ Reason member refused

☒ Member recently completed

☐ Scheduled to complete

☐ Member apprehension

☐ Not interested

☐ Other

↳ FOBT Test Barcode

↳ Exam Date

↳ Screening Result

↳ Diagnosis

↳ Comments

A1C

☒ Yes

☐ No

↳ Status options

☒ Member refused

☐ Left kit

☐ Collected Sample

☐ Mail Kit direct to member

↳ Reason member refused

☐ Member recently completed

☐ Scheduled to complete

☐ Member apprehension

☒ Not interested

☐ Other

↳ A1C Test Barcode

- ↳

Exam Date
- ↳

Screening Result
- ↳

Diagnosis
- ↳

Comments

LDL

☒ Yes

☐ No

↳

Status options

☐ Member refused

☒ Left kit

☐ Collected Sample

☐ Mail Kit direct to member

↳

LDL Test Barcode

↳

Exam Date

↳

Screening Result

↳

Diagnosis

↳

Comments

RETINAL EYE EXAM

☐ Yes

☒ No

DEXA

☐ Yes

☒ No

PAD

☐ Yes

☒ No

☐ Member educated on results, verbalized understanding

Mini-Cog

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.

Recommendations

- ☐ Further cognitive evaluation needed
- ☐ Other

Home Safety & Personal Goals

In the past year how many times have you Fallen?

- ☐ None
- ☒ Once
- ☐ Twice
- ☐ Three times
- ☐ More than three times

Do you worry about falling or feeling unsteady when standing or walking

☐ Yes

☐ No

Worries about falling or feeling unsteady when standing or walking?

☐ Yes

☐ No

Did you have a fracture in past 6 months?

☒ Yes

☐ No

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

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

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

Have you ever physically or felt emotionally abused by someone

☐ Yes ☐ No

Feeling like harming others or yourself

☒ Yes ☐ No

- Who do you feel like harming?
- Do you feel like this at this momen?
- Are you in a safe place?
- Would you like me to assist you to call 911?

Are you afraid of anyone or is anyone hurting you?

☒ Yes ☐ No

- Who are you afraid of? Are you afraid at this moment?
- Who is hurting you? Are you being hurt at this moment?
- Are you in a safe place?
- Would you like me to assist you to call 911?

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

Provider Signature	
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?

The information obtained today and any applicable lab results (some of which may become available after subsequent analysis) may be sent to your primary care physician (PCP).