HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	CLAYTON L TERRETTA
Evaluator Name :	test clinicianFE, FNP
Assessment Type :	Health Risk Assessment
DOB :	1928-07-05
Evaluation Date :	2022-4-29 07:01 PM
Visit Type :	Virtual: Video & Audio Capability

Demographics

Plan	VPHP
Program	MEDICARE
LOB	DSNP
Name	CLAYTON L TERRETTA
Gender	Male
Address	3002 LUCK LANE
City	HOPEWELL
State	VA
Zip	23860-4211
Date of Birth	1928-07-05
Age(as of date)	93
Marital Status	
Member Identification Number	11000358
HICN	
Phone Number	8046657146
Cell Number	
Alternate Contact Number	
Email	
Emergency Contact	
Phone Number	
Primary Care Physician	PASCO, HAYDEN
Phone Number	
PCP Address	12018 W Broad St Ste 100
PCP City	Richmond
PCP State	VA

PCP Zip	232337796
PCP County	
Office ID	
Office Name	PRIMARY HEALTH GROUP INC

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
  - **When**
    - ☐ Stopped within the last year ☐ Stopped within the last 3 years ☐ Stopped 5 or more years ago

Type
- ☐ Cigarettes
- ■ Cigars
- ☐ Chewing Tobacco
- ☐ Vaping
- ☐ Other

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

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

Do you use any assistive devices or DME?

- ☐ None
- ☐ Cane
- ☐ Walker
- ☐ Prosthesis
- ■ **Oxygen**
- ☐ Wheel Chair
- ☐ Bedside Commode
- ☐ Urinal
- ☐ Bed Pan
- ■ **CPAP**
- ☐ Other

Describe

- ☐ PRN
- ☐ Continuous
- ☐ Day
- ☐ Night

Litres / Min

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				☐	☐
Colorectal Screening				☐	☐
Influenza Vaccine			N/A	☐	☐
COVID-19 Vaccine			N/A	☐	☐
Pneumococcal Vaccine			N/A	☐	☐
Herpes Zoster Vaccine			N/A	☐	☐
Diabetes Screening			N/A	☐	☐
Diabetic Foot Exam			N/A	☐	☐

Cholesterol Screening			N/A	☐	☐
Glaucoma Screening			N/A	☐	☐
STIs/HIV Screening			N/A	☐	☐
Cervical Cancer Screening			N/A	☐	☐
Osteoporosis Screening				☐	☐
Prostate Screening			N/A	☐	☐
Fall Risk Screening			N/A	☐	☐

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

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	Yes	No

told to you by the doctor or pharmacist?		
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

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

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

Gait

☐ Normal ☐ Limp ☐ Wide based

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

Recommendations

- ☐ Take medications as prescribed
- ☐ Other

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

- ☐ Yes
- ☐ No

Recommendations

- ☐ Take medications as prescribed
- ☐ Other

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

- ☐ Yes
- ☐ No

Recommendations

- ☐ Discuss PT/OT evaluation with PCP
- ☐ Take medications as prescribed
- ☐ Other

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

- ☐ Yes
- ☐ No

Recommendations

- ☐ Take medications as prescribed
- ☐ Other

Endocrine Problems

- ☐ Yes
- ☐ No

Recommendations

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

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

- ☐ Yes
- ☐ No

Recommendations

- ☐ Take medications as prescribed
- ☐ Report abnormal bruising or bleeding
- ☐ Follow up with doctor for lab work
- ☐ Other

Cancer

Diagnosis of Cancer	Yes	No

Recommendations

- ☐ Take medications as prescribed
- ☐ Other

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	BMI
(Feet)	(Inch)	(lbs)	

☐ Obesity ☐ Moderate Obesity ☐ Morbid Obesity
☐ Malnutrition

Are you on a special diet?

☐ Heart Healthy Diet ☐ Diabetic Diet ☐ Renal Diet
☐ Vegetarian ☐ Vegan ☐ Gluten Free
☐ Keto ☐ Pescatarian ☐ Other

Have you lost weight in the past 6 months?

☐ None ☐ 5lbs ☐ 10lbs
☐ 15lbs ☐ More than 15lbs ☐ 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 trubinates:	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**

FOBT

■ **Yes** ☐ No

- **Status options**
  - ☐ Member refused ☐ Left kit ☐ Collected Sample
  - ☐ Mail Kit direct to member
- **FOBT Test Barcode**
- **Exam Date**
- **Screening Result**
- **Diagnosis**

Comments

A1C

☐ Yes ■ No

LDL

☐ Yes ■ No

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

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

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	■
Date/Time of Service/Evaluation :	
Time exam finished	
I accept the Disclosure Statement	■
Consented to Video chat	■
Provider Signature	shwe Digitally signed by test clinicianFE, FNP 2022-04-27, 19:28
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).