

HRA Form

Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	CHERYL L CALE
Evaluator Name :	test clinicianFE, FNP
Assessment Type :	Health Risk Assessment
DOB :	1955-02-02
Evaluation Date :	2022-6-1 05:32 PM
Visit Type :	In Person

Demographics

Plan	VPHP
Program	MEDICARE
LOB	DSNP
Name	CHERYL L CALE
Gender	Female
Address	106 CLIFFVIEW DR
City	COVINGTON
State	VA
Zip	24426-5804
Date of Birth	1955-02-02
Age(as of date)	67
Marital Status	Married
Member Identification Number	11001391
HICN	
Phone Number	5409658903
Cell Number	
Alternate Contact Number	123
Email	abc@gmail.com
Emergency Contact	
Phone Number	321
Primary Care Physician	HENDERSON, ROBERT J
Phone Number	123
PCP Address	2145 Mount Pleasant Blvd SE
PCP City	Roanoke
PCP State	VA

PCP Zip	240143632
PCP County	909
Office ID	
Office Name	PATRICIA W HENDERSON DO

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**
- If other,
- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> African languages | <input type="checkbox"/> Arabic | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> French | <input type="checkbox"/> French Creole | <input type="checkbox"/> German |
| <input type="checkbox"/> Greek | <input type="checkbox"/> Gujarati | <input type="checkbox"/> Hebrew |
| <input checked="" type="checkbox"/> Hindi | <input type="checkbox"/> Hungarian | <input type="checkbox"/> Italian |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean | <input type="checkbox"/> Persian |
| <input type="checkbox"/> Polish | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Scandinavian Languages | <input type="checkbox"/> Serbo-Croatian | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Tagalog | <input type="checkbox"/> Urdu | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Yiddish | | |

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?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
Developed Shortness of breath?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> 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
Type
☐ Cigarettes ☒ Cigars ☐ Chewing Tobacco
☐ Vaping ☐ Other

☒ Discussed smoking cessation options, member verbalized understanding

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

☐ Member educated on advance care planning
☐ Declines discussion at this time

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
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↳ 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
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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	Not Applicable			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

Screening					
Colorectal Screening				<input checked="" type="checkbox"/>	<input type="checkbox"/>
Influenza Vaccine	Yes		N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
COVID-19 Vaccine			N/A	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pneumococcal Vaccine	Yes		N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Herpes Zoster Vaccine	Not Applicable		N/A	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Diabetes Screening			N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Diabetic Foot Exam	No		N/A	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Cholesterol Screening			N/A	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Glaucoma Screening	Don't Know		N/A	<input type="checkbox"/>	<input type="checkbox"/>
STIs/HIV Screening			N/A	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Cervical Cancer Screening			N/A	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis Screening	Don't Know			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Prostate Screening	No		N/A	<input type="checkbox"/>	<input type="checkbox"/>
Fall Risk Screening			N/A	<input checked="" type="checkbox"/>	<input checked="" 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

☒ Education Provided

☐ 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

☐ Anticoagulants

☐ Steroids

☐ Statins

☒ Insulin

☒ 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

Diagnoses

☐ Difficulty with Hearing

☐ Legally Deaf

☒ Tinnitus

☐ Vertigo

☐ Other

Tinnitus

Describe

☐ Active

☐ History of

☒ Rule out

Supported by

☐ History

☒ Symptoms

☐ Physical Findings

☐ Medications

☐ Test results

☐ Image studies

☒ Biopsy ☐ DME ☐ Other

Nose Problems (Nose Bleeds, Sinus infections, Other)

☒ Yes ☐ No

Diagnoses

- ☐ Allergic Rhinitis
- ☐ Nose Bleeds
- ☐ Sinus Infections

☒ Other

Chronic Post Nasal Drip

Describe

☐ Active

Supported by

- ☒ History
- ☐ Medications
- ☐ Biopsy

Other

Describe

☐ Active

Supported by

- ☐ History
- ☐ Medications
- ☐ Biopsy

Other

☒ Chronic Post Nasal Drip

- ☐ Seasonal Allergies
- ☐ Sinusitis

☒ History of

- ☐ Symptoms
- ☐ Test results
- ☐ DME

☐ Rule out

☒ Physical Findings

- ☒ Image studies
- ☐ Other

☐ History of

- ☐ Symptoms
- ☐ Test results
- ☐ DME

☐ Rule out

☐ Physical Findings

- ☒ Image studies
- ☐ Other

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

- | | |
|---|--|
| <input checked="" type="checkbox"/> Alcohol Dependence | <input checked="" type="checkbox"/> Amyotrophic Lateral Sclerosis |
| <input checked="" type="checkbox"/> Anxiety | <input checked="" type="checkbox"/> Bipolar Disorder |
| <input checked="" type="checkbox"/> Cerebral Hemorrhage | <input checked="" type="checkbox"/> Cerebral Palsy |
| <input checked="" type="checkbox"/> Delusional Disease | <input checked="" type="checkbox"/> Dementia |
| <input checked="" type="checkbox"/> Depression | <input checked="" type="checkbox"/> Drug Dependence |
| <input checked="" type="checkbox"/> Fibromyalgia | <input checked="" type="checkbox"/> Guillain-Barre Disease |
| <input checked="" type="checkbox"/> Hemiparesis | <input checked="" type="checkbox"/> Huntington's Chorea |
| <input checked="" type="checkbox"/> Insomnia | <input checked="" type="checkbox"/> Intellectual and or Developmental Disability |
| <input checked="" type="checkbox"/> Migraine Headaches | <input checked="" type="checkbox"/> Multiple Sclerosis |
| <input checked="" type="checkbox"/> Muscular Dystrophy | <input checked="" type="checkbox"/> Myasthenia Gravis |
| <input checked="" type="checkbox"/> Parkinson's disease | <input checked="" type="checkbox"/> Peripheral Neuropathy |
| <input checked="" type="checkbox"/> Restless leg syndrome | <input checked="" type="checkbox"/> Schizophrenia |
| <input checked="" type="checkbox"/> Seizures | <input checked="" type="checkbox"/> Spinal Cord Injury |
| <input checked="" type="checkbox"/> Stroke | <input checked="" type="checkbox"/> Subdural Hematoma |
| <input checked="" type="checkbox"/> TIA | <input checked="" type="checkbox"/> Traumatic Brain Injury |

☐ Other

Alcohol Dependence

☐ Describe

☒ **Active** ☐ History of ☐ Rule out

☐ Type

☐ Episodic ☒ **Continuous** ☐ Remission

☐ Supported by

☒ **Drinking history** ☒ **Hospitalizations** ☒ **Physical findings**

☐ Lab results ☐ Other

☐ History of Delirium Tremens

☒ **Yes** ☐ No

☐ History of Psychosis

☒ **Yes** ☐ No

Amyotrophic Lateral Sclerosis

☐ Describe

☒ **Active** ☐ History Of ☐ Rule out

☐ Supported by

☒ **Progressive weakness** ☒ **Slurring of speech** ☒ **Abnormal gait**

☒ **Difficulty swallowing** ☐ EMG ☐ Other

Anxiety

☐ Describe

☐ Active ☒ **History of** ☐ Rule out

☐ Type

☒ **Generalized Anxiety Disorder** ☒ **Panic Disorder** ☒ **Obsessive-Compulsive Disorder**

☒ **Post traumatic stress disorder** ☐ Social Phobia ☐ Other

☐ Supported by

☐ Symptoms ☐ GAD 7 ☒ **Antianxiety medication**

☐ Other

Bipolar Disorder

☐ Describe

☒ **Active** ☐ History of ☐ Rule out

☐ Type

☒ **Manic Depression** ☐ Bipolar Depression ☐ Mixed

☐ Unknown

☐ Supported by

☐ History of mood swings ☒ **Medication** ☐ Other

Cerebral Hemorrhage

☐ Describe

☒ **Active** ☐ History of ☐ Rule out

☐ Supported by

<input type="checkbox"/> Hospitalization	<input checked="" type="checkbox"/> Image study	<input checked="" type="checkbox"/> Physical findings
<input checked="" type="checkbox"/> Sensory findings	<input type="checkbox"/> Other	
Physical findings		
↳ Physical findings		
<input checked="" type="checkbox"/> None	<input checked="" type="checkbox"/> Right arm paralysis	<input checked="" type="checkbox"/> Left arm paralysis
<input checked="" type="checkbox"/> Right leg paralysis	<input checked="" type="checkbox"/> Left leg paralysis	<input checked="" type="checkbox"/> Right hemiparesis
<input checked="" type="checkbox"/> Left hemiparesis	<input checked="" type="checkbox"/> Aphasia	<input checked="" type="checkbox"/> Apraxia
<input checked="" type="checkbox"/> Cranial nerve paralysis	<input checked="" type="checkbox"/> Paraplegia	<input checked="" type="checkbox"/> Quadriplegia
<input type="checkbox"/> Coma		
Sensory findings		
↳ Sensory findings		
<input checked="" type="checkbox"/> None	<input checked="" type="checkbox"/> Numbness right arm	<input checked="" type="checkbox"/> Numbness right leg
<input checked="" type="checkbox"/> Numbness left arm	<input type="checkbox"/> Numbness left leg	<input checked="" type="checkbox"/> Facial numbness
<input type="checkbox"/> Paresthesias		
Cerebral Palsy		
↳ Describe		
<input type="checkbox"/> Active	<input checked="" type="checkbox"/> History of	<input type="checkbox"/> Rule out
↳ Supported by		
<input type="checkbox"/> Physical exam	<input checked="" type="checkbox"/> History	<input checked="" type="checkbox"/> Laboratory testing
<input type="checkbox"/> Other		
Delusional Disease		
↳ Describe		
<input type="checkbox"/> Active	<input checked="" type="checkbox"/> History of	<input type="checkbox"/> Rule out
↳ Supported by		
<input checked="" type="checkbox"/> Affect	<input checked="" type="checkbox"/> Specific symptoms for 6 months or more	<input checked="" type="checkbox"/> Medication
<input checked="" type="checkbox"/> Hospitalization	<input type="checkbox"/> Other	
Dementia		
↳ Describe		
<input checked="" type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
↳ Supported by		
<input checked="" type="checkbox"/> Behavioral changes	<input checked="" type="checkbox"/> Mental testing	<input checked="" type="checkbox"/> MRI
<input checked="" type="checkbox"/> Functional changes	<input type="checkbox"/> Other	
↳ Type of Dementia		
<input type="checkbox"/> Vascular	<input checked="" type="checkbox"/> Alzheimer's disease	<input type="checkbox"/> Etiology Unknown
Depression		
↳ Describe		
<input checked="" type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
↳ Supported by		
<input checked="" type="checkbox"/> Symptoms	<input checked="" type="checkbox"/> PHQ 2 / 9	<input checked="" type="checkbox"/> Use of antidepressant medication
<input type="checkbox"/> Other		
↳ Major		

<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
↳ Supported by <input type="checkbox"/> PHQ 9	<input type="checkbox"/> Hospitalization	<input checked="" type="checkbox"/> Chronic use of antidepressant medication beyond 6 months
<input type="checkbox"/> Use of ECT		
↳ Episodes <input checked="" type="checkbox"/> Single <input type="checkbox"/> Unknown	<input type="checkbox"/> Recurrent	<input type="checkbox"/> In Remission
Drug Dependence ↳ Describe <input checked="" type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
↳ Type <input type="checkbox"/> Episodic	<input type="checkbox"/> Continuous	<input checked="" type="checkbox"/> Remission
↳ Supported by <input checked="" type="checkbox"/> Use of recreational drugs <input checked="" type="checkbox"/> History outpatient treatment <input type="checkbox"/> Other	<input checked="" type="checkbox"/> Chronic use of pain medication <input checked="" type="checkbox"/> Withdrawal symptoms	<input checked="" type="checkbox"/> History of hospitalization <input checked="" type="checkbox"/> Abnormal affect
↳ History of Psychosis <input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
↳ What drug/s		
Fibromyalgia ↳ Describe <input type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
↳ Supported by <input checked="" type="checkbox"/> Symptoms <input checked="" type="checkbox"/> Medications	<input checked="" type="checkbox"/> Physical findings <input type="checkbox"/> Other	<input checked="" type="checkbox"/> History
Guillain-Barre Disease ↳ Describe <input checked="" type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
↳ Supported by <input checked="" type="checkbox"/> Physical findings <input type="checkbox"/> Other	<input checked="" type="checkbox"/> EMG / Nerve Conduction studies	<input checked="" type="checkbox"/> Hospitalization
Hemiparesis ↳ Describe <input checked="" type="checkbox"/> Active	<input type="checkbox"/> History Of	<input type="checkbox"/> Rule out
↳ Describe <input checked="" type="checkbox"/> Left sided	<input checked="" type="checkbox"/> Right sided	
↳ Supported by <input checked="" type="checkbox"/> Physical findings	<input checked="" type="checkbox"/> History	<input type="checkbox"/> Other
Huntington's Chorea ↳ Describe <input type="checkbox"/> Active	<input type="checkbox"/> History Of	<input type="checkbox"/> Rule out

- ↳ **Supported by**
 - **Family history**
 - **Chorea movement**
 - **Physical findings**
 - Other
- Insomnia**
- ↳ **Describe**
 - Active
 - History Of
 - Rule out
- ↳ **Supported by**
 - **Medication**
 - **Symptoms**
 - History
 - Other
- Intellectual and or Developmental Disability**
- ↳ **Describe**
 - Active
 - History of
 - Rule out
- ↳ **Supported by**
 - **History**
 - Symptoms
 - **Physical Findings**
 - **Medications**
 - **Test results**
 - Image studies
 - **Biopsy**
 - DME
 - Other
- ↳ **Describe**
 - Down's Syndrome
 - **Psychomotor Retardation**
 - Other
- Migraine Headaches**
- ↳ **Describe**
 - Active
 - History of
 - Rule out
- ↳ **Supported by**
 - **History**
 - **Symptoms**
 - **Medications**
 - Other
- Multiple Sclerosis**
- ↳ **Describe**
 - **Active**
 - History of
 - Rule out
- ↳ **Supported by**
 - **Physical findings**
 - **Laboratory testing**
 - **Medications**
 - Bowel or bladder dysfunction
 - Hospitalization
 - Other
- Muscular Dystrophy**
- ↳ **Describe**
 - Active
 - History Of
 - Rule out
- ↳ **Supported by**
 - **Physical findings**
 - EMG's
 - **History of progressive muscle weakness**
 - **Family history**
 - Other
- Myasthenia Gravis**
- ↳ **Describe**
 - Active
 - History Of
 - Rule out
- ↳ **Supported by**
 - **Ptosis**
 - **Double vision**
 - **Difficulty chewing**
 - **Difficulty swallowing**
 - Tensilon test
 - Medication

- Other
- Parkinson's disease
 - Describe
 - Active
 - History of
 - Rule out
 - Supported by
 - Physical findings
 - Gait
 - Dementia
 - Affect
 - Other
- Peripheral Neuropathy
 - Describe
 - Active
 - History Of
 - Rule out
 - Supported by
 - Physical findings
 - EMG / Nerve Conduction studies
 - Biopsy
- Other
- Secondary to Diabetes
 - Yes
 - No
- Restless leg syndrome
 - Describe
 - Active
 - History Of
 - Rule out
 - Supported by
 - Symptoms
 - Medication
 - History
 - Other
- Schizophrenia
 - Describe
 - Active
 - History of
 - Rule out
 - Supported by
 - Affect
 - Specific symptoms for 6 months or more
 - Medication
 - Hospitalization
 - Psychosis
 - Other
- Seizures
 - Describe
 - Active
 - History of
 - Rule out
 - Type
 - Seizure Disorder
 - Seizure, unspecified
 - Treatment
 - Supported by
 - History of recurrent seizures
 - Medications
 - Laboratory testing
 - Other
- Spinal Cord Injury
 - Describe
 - Active (within 8 months)
 - History of
 - Rule out
 - Supported by
 - Paresis or paralysis
 - Loss of sensation
 - Bowel or bladder dysfunction

- ☒ **Hospitalization** ☐ **Other**
- Paresis or paralysis**
 - ☐ **Paresis, paralysis or loss of sensation**
 - ☒ **None** ☒ **Paraplegia** ☒ **Quadriplegia**
 - ☒ **Anterior Cord Syndrome** ☒ **Posterior Cord Syndrome** ☒ **Central Cord Syndrome**
 - Loss of sensation**
 - ☐ **Paresis, paralysis or loss of sensation**
 - ☒ **None** ☒ **Paraplegia** ☒ **Quadriplegia**
 - ☒ **Anterior Cord Syndrome** ☒ **Posterior Cord Syndrome** ☒ **Central Cord Syndrome**
 - ☐ **Secondary to**
 - ☒ **Fracture** ☐ **Dislocation** ☐ **Compressive Lesion**
- Stroke**
 - ☐ **Describe**
 - ☒ **Active** ☐ **History of** ☐ **Rule out**
 - ☐ **Supported by**
 - ☒ **Hospitalization** ☒ **Image study** ☒ **Physical findings**
 - ☐ **Sensory findings** ☐ **Other**
 - Physical findings**
 - ☐ **Physical findings**
 - ☒ **None** ☒ **Right arm paralysis** ☒ **Left arm paralysis**
 - ☒ **Right leg paralysis** ☐ **Left leg paralysis** ☒ **Right hemiparesis**
 - ☒ **Left hemiparesis** ☒ **Aphasia** ☒ **Apraxia**
 - ☐ **Cranial nerve paralysis** ☒ **Functional Quadriplegia**
- Subdural Hematoma**
 - ☐ **Describe**
 - ☒ **Active** ☐ **History of** ☐ **Rule out**
 - ☐ **Supported by**
 - ☐ **Hospitalization** ☐ **Image study** ☐ **Physical findings**
 - ☐ **Sensory findings** ☐ **Other**
- TIA**
 - ☐ **Describe**
 - ☒ **Active** ☐ **History of** ☐ **Rule out**
 - ☐ **Supported by**
 - ☒ **History** ☒ **Physical exam** ☒ **Image studies**
 - ☐ **Other**
- Traumatic Brain Injury**
 - ☐ **Describe**
 - ☒ **Active** ☐ **History of** ☐ **Rule out**
 - ☐ **Supported by**
 - ☒ **Hospitalization** ☒ **Image studies** ☒ **Physical findings**
 - ☐ **Other**
 - Physical findings**
 - ☐ **Physical findings**
 - ☒ **None** ☒ **Coma** ☒ **Quadriplegia**

☐ Paraplegia
 ☐ Hemiplegia
 ☒ **Monoplegia**
☒ **PT/OT**
☐ DME

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

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

14

If Score is Greater than 15, recommend additional treatment

Score	Depression Severity
1 - 4	Minimal Depression
5 - 9	Mild Depression
10 - 14	Moderate Depression
15 - 19	Moderately Severe Depression
20 - 27	Severe Depression

comments

comens

Speech

- ☒ **Normal**
- ☐ Apraxia

☐ Slurred

☐ Aphasic

Finger to Nose

☐ Normal

☒ If abnormal

☒ **Left**

☒ **Abnormal**

☐ Right

☐ Both

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

☐ 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

☒ Erectile Dysfunction

☒ Gynecological

☒ Nephritis or Nephrosis

☒ Other
- ☒ ESRD

☒ Frequent UTI

☒ Kidney Stones

☒ Urinary Incontinence

Acute Renal Failure

- ☒ Describe

☒ Active

☐ History of

☐ Rule out
- ☒ Supported by

☐ Lab tests

☒ Calculated GFR

☐ Hospitalization

☐ Other
- ☒ Etiology

comments

ediologies

BPH

- ☒ Describe

☒ Active

☐ History of

☐ Rule out
- ☒ Supported by

☒ Physical exam

☒ Symptoms

☒ Lab test

☒ Biopsy

☒ Medication

☒ Hospitalization
- ☒ Other

Other

- ☒ Describe
- ☒ Chronic Kidney Disease

☒ Describe

☒ Active

☐ History of

☐ Rule out

☒ Supported by

☒ Lab tests

☐ Calculated GFR X 3

☐ Other

☐ What stage

☐ Stage 1

☐ Stage 2

☐ Stage 3a

☐ Stage 3b

☐ Stage 4

☐ Stage 5

☒ UnKnown

☒ Secondary to Diabetes

☒ Yes

☐ No

☐ UnKnown

☒ Secondary to Hypertension

☒ Yes

☐ No

☐ UnKnown

ESRD

- ☒ Describe

☒ Active

☐ History of

☐ Rule out
- ☒ Supported by

☒ Lab tests

☒ Calculated GFR X 3

☒ Symptoms

☒ Other
- ☒ Other

☒ Describe

☒ Patient on dialysis

☒ Yes

☐ No

☒ Type

☒ Hemodialysis

☐ Peritoneal dialysis

Location

☒ In Home

☐ Dialysis Center

Dialysis schedule

comments

Dialysis schedule

Type and location of access device

comments

ype and location of access devi

On a special diet

☒ Yes

☐ No

Erectile Dysfunction

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ History

☒ Symptoms

☒ Physical Findings

☒ Medications

☒ Test results

☒ Other

Other

Describe

comments

describe

Frequent UTI

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Symptoms

☒ Cultures

☒ Laboratory results

☒ Other

Other

Describe

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

☐ History of

☐ Rule out

Supported by

☒ Medical history

☒ Lab tests

☒ Imaging studies

☒ Biopsy

☒ Medications

☐ Other

Urinary Incontinence

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

☒ History

☒ Symptoms

☒ Physical Findings

☒ Medications

☒ Test results

☒ DME

☒ Other

Other

Describe

Related to stress

☒ Yes

☐ No

Related to

☒ Dribbling

☐ Urgency

☐ Other

Describe

☒ Daily

☐ Few times a week

☐ Less than once a week

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

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

☒ Yes

☐ No

Diagnoses

☒ Collagen (Connective) Tissue Disease

☒ Degenerative Disc Disease

☒ Extremity Fracture

☒ Gout

☒ Hallux Valgus

☒ Hammer Toes

☒ Osteoarthritis

☒ Osteomyelitis

☒ Osteoporosis

☒ Pyogenic Arthritis

☒ Rheumatoid Arthritis

☒ Spinal Stenosis

☒ Systemic Lupus Erythematosus

☐ Other

Collagen (Connective) Tissue Disease

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Physical Findings

☒ Lab tests

☒ Biopsy

☒ Image studies

☒ Other

Describe

- SLE(Lupus)

Degenerative Disc Disease

Describe

Active

Supported by

Symptoms

Medications

Other

Describe

Scleroderma

History of

Physical Findings

Other

Dermatomyositis

Rule out

Image studies
- comments
- described
- Normal bladder and bowel function

Yes

Site of disease

Cervical

Lumbosacral

Extremity Fracture

Describe

Active

Type

Traumatic

Supported by

History

Medications

Biopsy

Extremity

Shoulder

Wrist

Tibia

Foot

Shoulder

Laterality

Right

Arm

Laterality

Right

Forearm

Laterality

Right

Wrist

Laterality

Right

Hand

Laterality

Right

Femoral Shaft

Laterality

Right

No

Thoracic

Other

History of

Pathological

Symptoms

Test results

DME

Arm

Hand

Fibula

Hip

Left

Left

Left

Left

Left

Left

Left

Lumbar

Rule out

Physical Findings


Image studies

Other

Forearm

Femoral Shaft

Ankle



FOCUSCARE

23

Tibia

↳ Laterality

☒ Right
☒ Left

Fibula

↳ Laterality

☒ Right
☒ Left

Ankle

↳ Laterality

☒ Right
☒ Left

Foot

↳ Laterality

☒ Right
☒ Left

Hip

↳ Laterality

☒ Right
☒ Left

↳ 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

☒ History
☒ Symptoms
☒ Physical Findings
☒ Medications
☒ Test results
☒ Image studies
☒ Biopsy
☐ DME
☒ Other

Osteoarthritis

↳ Describe

☒ Active
☐ History of
☐ Rule out

↳ Supported by

☒ Symptoms
☒ Physical Findings
☒ Image studies
☒ Other

Symptoms

↳ Describe

☒ Joint swelling
☒ Joint stiffness
☒ Pain

☒ Limited ROM

↳ Which joints

comments

which join

Osteomyelitis

↳ Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

↳ Supported by

- ☒ Hospitalization
- ☒ Image studies
- ☒ Cultures
- ☒ Medications
- ☐ Other

Osteoporosis

↳ Describe

- ☐ Active
- ☐ History of
- ☒ Rule out

↳ Supported by

- ☒ DEXA scan
- ☒ Medications
- ☒ Imaging studies
- ☒ Symptoms
- ☒ Fracture history
- ☐ Other

Pyogenic Arthritis

↳ Describe

- ☐ Active
- ☐ History of
- ☒ Rule out

↳ Supported by

- ☒ Hospitalization
- ☒ Image studies
- ☒ Cultures
- ☒ Medications
- ☐ Other

↳ Which joint/s

comments

joins

Rheumatoid Arthritis

↳ Describe

- ☐ Active
- ☒ History of
- ☐ Rule out

↳ Supported by

- ☒ Symptoms
- ☒ Physical findings
- ☒ Medications
- ☒ Lab tests
- ☒ Image Studies
- ☐ Other

Symptoms

↳ Describe

- ☒ Joint swelling
- ☒ Joint stiffness
- ☒ Pain
- ☒ Limited ROM

↳ Which joints

Spinal Stenosis

↳ Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

↳ Supported by

- ☒ Symptoms
- ☒ Physical Findings
- ☒ Image studies
- ☒ Medications
- ☐ Other

↳ Normal bladder and bowel function

- ☒ Yes
- ☐ No

Systemic Lupus Erythematosus

↳ Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

↳ Supported by

- ☒ Labs
- ☒ Medications
- ☒ History

☐ other

Have you had an amputation?

☒ Yes

Describe

☐ No

describe

- Recommendations
- ☒ Discuss PT/OT evaluation with PCP

☒ Take medications as prescribed

☒ Other

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

☒ Yes

Diagnoses

☐ No

- ☒ Basil Cell Carcinoma

☒ Eczema

☒ Psoriasis

☒ Tinea Pedis

☒ Wound

- ☒ Dermatitis

☒ Onychomycosis

☒ Skin ulcer

☒ Urticarial Disease

☐ Other

Basil Cell Carcinoma

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

- ☒ History

☒ Medications

☒ Biopsy

- ☒ Symptoms

☒ Test results

☒ DME

- ☒ Physical Findings

☒ Image studies

☐ Other

Dermatitis

Describe

☐ Active

☐ History of

☐ Rule out

Supported by

- ☒ History

☒ Medications

☒ Biopsy

- ☒ Symptoms

☒ Test results

☒ DME

- ☒ Physical Findings

☒ Image studies

☐ Other

What type

- ☐ Contact

☐ Disease Induced

- ☐ Stasis

☐ Unspecified

☒ Drug induced

Eczema

Describe

☐ Active

☐ History of

☒ Rule out

Supported by

- ☒ History

☒ Medications

☒ Biopsy

- ☒ Symptoms

☒ Test results

☒ DME

- ☒ Physical Findings

☒ Image studies

☐ Other

Onychomycosis

Describe

☐ Active

☐ History of

☒ Rule out

Supported by

- ☒ History

- ☒ Symptoms

- ☒ Physical Findings

<ul style="list-style-type: none"> Medications Biopsy 	<ul style="list-style-type: none"> Test results DME 	<ul style="list-style-type: none"> Image studies Other
Psoriasis <ul style="list-style-type: none"> Describe <ul style="list-style-type: none"> Active Supported by <ul style="list-style-type: none"> History Medications Biopsy History of Psoriatic Arthritis <ul style="list-style-type: none"> Yes 	<ul style="list-style-type: none"> History of Symptoms Test results DME No 	<ul style="list-style-type: none"> Rule out Physical Findings Image studies Other
Skin ulcer <ul style="list-style-type: none"> Describe <ul style="list-style-type: none"> Active Supported by <ul style="list-style-type: none"> History Medications Biopsy Etiology <ul style="list-style-type: none"> Pressure 	<ul style="list-style-type: none"> History of Symptoms Test results DME Venous Stasis Diabetic Vasculitis 	<ul style="list-style-type: none"> Rule out Physical Findings Image studies Other Peripheral Vascular Disease Diabetic Neuropathy
<ul style="list-style-type: none"> Disease Induced 	<ul style="list-style-type: none"> Diabetic Vasculitis 	<ul style="list-style-type: none"> Diabetic Neuropathy
Tinea Pedis <ul style="list-style-type: none"> Describe <ul style="list-style-type: none"> Active Supported by <ul style="list-style-type: none"> History Medications Biopsy 	<ul style="list-style-type: none"> History of Symptoms Test results DME 	<ul style="list-style-type: none"> Rule out Physical Findings Image studies Other
Urticarial Disease <ul style="list-style-type: none"> Describe <ul style="list-style-type: none"> Active Supported by <ul style="list-style-type: none"> History Medications Biopsy Type <ul style="list-style-type: none"> Acute Etiology 	<ul style="list-style-type: none"> History of Symptoms Test results DME Chronic 	<ul style="list-style-type: none"> Rule out Physical Findings Image studies Other
Wound <ul style="list-style-type: none"> Describe <ul style="list-style-type: none"> Active Supported by <ul style="list-style-type: none"> History Medications Biopsy Etiology 	<ul style="list-style-type: none"> History of Symptoms Test results DME 	<ul style="list-style-type: none"> Rule out Physical Findings Image studies Other

☒ Surgical

☐ Traumatic

☐ Burn

Recommendations

- ☒ Take medications as prescribed
- ☒ Other

Endocrine Problems

- ☒ Yes ☐ No

Diagnoses

- | | |
|---|---|
| <input checked="" type="checkbox"/> Chronic Kidney Disease secondary to Diabetes | <input checked="" type="checkbox"/> Coronary Artery Disease and Diabetes |
| <input checked="" type="checkbox"/> Cushing's Disease | <input checked="" type="checkbox"/> Diabetes |
| <input checked="" type="checkbox"/> Diabetic Retinopathy | <input checked="" type="checkbox"/> Secondary Hyperparathyroidism |
| <input checked="" type="checkbox"/> Hypertension and Diabetes | <input checked="" type="checkbox"/> Hyperthyroidism |
| <input checked="" type="checkbox"/> Hypothyroidism | <input checked="" type="checkbox"/> Peripheral Neuropathy secondary to Diabetes |
| <input checked="" type="checkbox"/> Peripheral Vascular Disease secondary to Diabetes | <input checked="" type="checkbox"/> Hyperparathyroidism |

Other

Chronic Kidney Disease secondary to Diabetes

Describe

- | | | |
|--|-------------------------------------|-----------------------------------|
| <input checked="" type="checkbox"/> Active | <input type="checkbox"/> History of | <input type="checkbox"/> Rule out |
|--|-------------------------------------|-----------------------------------|

Supported by

- | | | |
|---|---|---|
| <input checked="" type="checkbox"/> Decreased GFR | <input checked="" type="checkbox"/> Albuminuria | <input checked="" type="checkbox"/> Elevated BUN/Creatinine |
|---|---|---|

- | | |
|--|--------------------------------|
| <input checked="" type="checkbox"/> Dialysis | <input type="checkbox"/> Other |
|--|--------------------------------|

Patient on ACE or ARB

- | | |
|---|-----------------------------|
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|-----------------------------|

Coronary Artery Disease and Diabetes

Describe

- | | | |
|---------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Active | <input type="checkbox"/> History of | <input type="checkbox"/> Rule out |
|---------------------------------|-------------------------------------|-----------------------------------|

Supported by

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> History | <input checked="" type="checkbox"/> Symptoms | <input checked="" type="checkbox"/> Physical Findings |
| <input checked="" type="checkbox"/> Medications | <input checked="" type="checkbox"/> Test results | <input checked="" type="checkbox"/> Image studies |
| <input checked="" type="checkbox"/> Biopsy | <input checked="" type="checkbox"/> DME | <input type="checkbox"/> Other |

Is patient on a statin

- | | |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input checked="" type="checkbox"/> No |
|------------------------------|--|

Is patient on an aspirin

- | | |
|---|-----------------------------|
| <input checked="" type="checkbox"/> Yes | <input type="checkbox"/> No |
|---|-----------------------------|

Cushing's Disease

Describe

- | | | |
|---------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Active | <input type="checkbox"/> History of | <input checked="" type="checkbox"/> Rule out |
|---------------------------------|-------------------------------------|--|

Supported by

- | | | |
|---|---|--|
| <input checked="" type="checkbox"/> Physical exam | <input checked="" type="checkbox"/> Lab tests | <input checked="" type="checkbox"/> Suppression Test |
| <input type="checkbox"/> Other | | |

Diabetes

Describe

- | | | |
|---------------------------------|-------------------------------------|-----------------------------------|
| <input type="checkbox"/> Active | <input type="checkbox"/> History of | <input type="checkbox"/> Rule out |
|---------------------------------|-------------------------------------|-----------------------------------|

↳ **Supported by**

- ☒ Symptoms
- ☒ Physical findings
- ☒ Lab tests
- ☒ Medications
- ☐ Other

Symptoms

↳ **Describe**

- ☒ Increased thirst
- ☒ Shakiness
- ☒ Sweating
- ☒ Blurred vision

↳ **Type**

- ☐ Type 1
- ☒ Type 1.5
- ☐ Type 2
- ☐ Gestational

↳ **Most recent Hb A1C, value**

comments

a111c values

↳ **And Date**

comments

12/02/2022

↳ **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

Other

↳ **Describe**

comments

escribed

↳ **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
- ☒ History Vitamin D Deficiency
- ☒ History Celiac Disease
- ☒ Malabsorption
- ☒ Bariatric Surgery
- ☒ Lab tests
- ☒ History of kidney stones
- ☒ History of Fractures
- ☒ Imaging studies
- ☒ Fatigue
- ☐ Other

↳ **Due to kidney disease?**

<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Hypertension and Diabetes		
↳ Describe		
<input checked="" type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
↳ Supported by		
<input checked="" type="checkbox"/> History	<input checked="" type="checkbox"/> Symptoms	<input checked="" type="checkbox"/> Physical Findings
<input checked="" type="checkbox"/> Medications	<input checked="" type="checkbox"/> Test results	<input checked="" type="checkbox"/> Image studies
<input checked="" type="checkbox"/> Biopsy	<input checked="" type="checkbox"/> DME	<input checked="" type="checkbox"/> Other
Other		
↳ Describe		

comments

others

↳ Is patient on Ace or ARB		
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
Hyperthyroidism		
↳ Describe		
<input checked="" type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
↳ Supported by		
<input checked="" type="checkbox"/> Rapid Heart Beat	<input checked="" type="checkbox"/> Nervousness	<input checked="" type="checkbox"/> Weight Loss
<input checked="" type="checkbox"/> Heat Intolerance	<input checked="" type="checkbox"/> Tremor	<input checked="" type="checkbox"/> Lab Data
<input checked="" type="checkbox"/> History of treatment for Hyperthyroidism	<input checked="" type="checkbox"/> Hyper Reflexes	<input type="checkbox"/> Other
Hypothyroidism		
↳ Describe		
<input checked="" type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
↳ Supported by		
<input checked="" type="checkbox"/> Weight gain	<input checked="" type="checkbox"/> Fatigue	<input checked="" type="checkbox"/> Hair changes
<input checked="" type="checkbox"/> Depression	<input checked="" type="checkbox"/> Treatment for hypothyroidism	<input checked="" type="checkbox"/> Lab data
<input type="checkbox"/> Other		
Peripheral Neuropathy secondary to Diabetes		
↳ Describe		
<input type="checkbox"/> Active	<input checked="" type="checkbox"/> History of	<input type="checkbox"/> Rule out
↳ Supported by		
<input checked="" type="checkbox"/> Physical exam	<input checked="" type="checkbox"/> Medication	<input checked="" type="checkbox"/> Symptoms
<input type="checkbox"/> Other		
Symptoms		
↳ Describe		
<input checked="" type="checkbox"/> Numbness	<input checked="" type="checkbox"/> Pain	<input checked="" type="checkbox"/> Burning
<input checked="" type="checkbox"/> Decreased sensation to legs or feet		
↳ Patient sees Podiatrist		
<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
↳ How often		
<input type="checkbox"/> Once a year	<input checked="" type="checkbox"/> Twice a year	<input type="checkbox"/> Quarterly
Peripheral Vascular Disease secondary to Diabetes		
↳ Describe		
<input checked="" type="checkbox"/> Active	<input type="checkbox"/> History of	<input type="checkbox"/> Rule out
↳ Supported by		

- ☒ Physical exam
- ☒ Foot deformity
- ☐ Other
- ☒ Patient sees Podiatrist
 - ☒ Yes
 - ☒ How often
 - ☒ Once a year
 - ☐ No
 - ☐ Twice a year
 - ☐ Quarterly
- ☒ Hyperparathyroidism
 - ☒ Describe
 - ☒ Active
 - ☒ Supported by
 - ☒ Lab tests
 - ☒ Imaging studies
 - ☐ History of
 - ☐ Rule out
- ☒ Other
 - ☒ Describe
 - ☒ Active
 - ☒ Supported by
 - ☒ History
 - ☒ Medications
 - ☒ Biopsy
 - ☐ History of
 - ☐ Rule out
 - ☒ Symptoms
 - ☒ Test results
 - ☒ DME
 - ☒ Physical Findings
 - ☒ Image studies
 - ☐ Other

comments

described

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
- ☒ C. Difficile
- ☒ HIV
- ☒ Hospital Acquired MRSA Infection
- ☒ Sepsis
- ☒ Sickle Cell Trait
- ☒ Thrombocytopenia
- ☒ Vitamin D Deficiency
- ☒ Anemia
- ☒ Community Acquired MRSA Infection
- ☒ Herpes Zoster
- ☒ Immune Deficiency
- ☒ Sickle Cell Disease
- ☒ Thalassemia
- ☒ Tuberculosis
- ☒ Other

AIDS

Describe

- ☒ Active

☐ History of

☐ Rule out

Supported by

- ☒ Symptoms

☒ Physical findings

☒ History of

opportunistic
infections

- ☒ Medications
- ☒ Other

Other

Describe

comments

described

Is patient currently under treatment

- ☒ Yes
- ☐ No

Where

comments

weere

Anemia

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

- ☒ Lab tests
- ☒ Symptoms
- ☒ History of blood transfusion

- ☒ Other

Other

Describe

comments

described

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

Other

Describe

comments

described

Viral load

comments

viral load

C4

comments

vgfbgh

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

☐ Active

☐ History of

☒ Rule out

Supported by

☒ Cultures

☒ Hospitalization

☒ Medications

☒ Physical findings

☐ Other

Immune Deficiency

Describe

☐ Active

☐ History of

☐ Rule out

Supported by

☒ History

☒ Symptoms

☒ Physical Findings

☒ Medications

☒ Test results

☒ Image studies

☐ Other

Etiology

History of Opportunistic Infection

☒ Yes

☐ No

Sepsis

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☒ Blood Cultures

☒ Other cultures

☒ Symptoms

☒ Hospitalization

☒ Unstable vital signs

☐ Other

Sickle Cell Disease

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

☒ Family history

☒ Symptoms

☒ History of infections

☒ Hospitalizations

☐ Other

Sickle Cell Trait

Describe

☐ Active

☐ History of

☒ Rule out

- ↳ Supported by

☒ Family history

☒ Lab test

☒ Other

Other

↳ Describe

comments

famil isor

Thalassemia

- ↳ Describe

☐ Active

☐ History of

☐ Rule out
- ↳ Supported by

☒ Family history

☒ Symptoms

☒ Lab tests

☒ History of infections

☐ Other

Thrombocytopenia

- ↳ Describe

☐ Active

☒ History of

☐ Rule out
- ↳ Supported by

☒ Lab tests

☒ Physical findings

☒ History

☐ Other

Etiology

Tuberculosis

- ↳ Describe

☐ Active

☐ History of active TB

☐ TB Infection (positive PPD)

☒ Rule out active TB
- ↳ Supported by

☒ History

☒ Medications

☒ Imaging study

☒ Skin test

☒ Symptoms

☒ Positive culture
- ☐ Other

↳ Has patient been given BCG

☐ Yes

☒ No

☐ Unknown

↳ Has patient been treated for active Tuberculosis

☒ Yes

☐ No

☐ Unknown

↳ Has patient been treated for TB Infection

☒ Yes

☐ No

☐ Unknown

Vitamin D Deficiency

- ↳ Describe

☒ Active

☐ History of

☐ Rule out
- ↳ Supported by

☒ Labs

☐ Medications

☐ History

☐ 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
- Report abnormal bruising or bleeding
- Follow up with doctor for lab work
- Other

Cancer

Diagnosis of Cancer	Yes	No
---------------------	-----	----

Describe

- Active
- History of
- Rule out

Supported by

- Physical findings
- Hospitalization
- Treatments
- Lab tests
- Imaging studies
- Surgery
- Biopsy
- Other

Type

- Brain
- Head
- Neck
- Breast
- Lung
- Esophagus
- Stomach
- Liver
- Pancreas
- Colon
- Rectum
- Kidney
- Bladder
- Ovaries
- Uterus
- Prostate
- Bone
- Blood
- Lymph Nodes
- Skin
- Other

Specific type/s

DescribeActiveHistory ofRule out
Supported byPhysical findingsHospitalizationTreatmentsLab testsImaging studiesSurgeryB
TypeBrainHeadNeckBreastLungEsophagusStomachLiverPancreasColonRectumKidneyBlade
NodesSkinOther
Specific type/s

Stage or Classification specific to the cancer

specific to the cancer

Active treatment

- Yes
- No
- Active treatment
- Chemotherapy
- Radiation
- Stem Cell
- Bone Marrow
- Surgery
- Immune System
- Other

Side effects

- Nausea
- Vomiting
- Diarrhea
- Anemia
- Neutropenia
- Thrombocytopenia
- Weakness
- Loss of appetite
- Other

Is there a current finding of Metastasis?

- Yes
- No

Location

locations
 ↳ History / finding of Cachexia
☒ Yes ☐ No

Do you see a specialist?
☒ Yes ☐ No

↳ Provider
 providers

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 turbinates:	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?


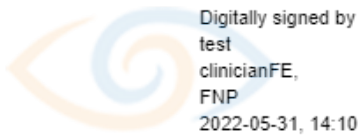
- ☐ **Yes**
- ☒ **No**

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	<input checked="" type="checkbox"/>
Date/Time of Service/Evaluation :	2022-05-31T00:06
Time exam finished	2022-06-01T00:07
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
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).