

HRA Form

Health Plan :	Test / Demo Healthcare
Member Name :	TEST MEMBER 41
Evaluator Name :	test clinicianFE, FNP
Assessment Type :	Health Risk Assessment
DOB :	1935-04-18
Evaluation Date :	2022-2-1 05:55 PM
Visit Type :	In Person

Demographics

Plan	Demo
Program	TEST
LOB	LOB
Name	TEST MEMBER 41
Gender	Male
Address	hgthjy
City	hygyju
State	hjuyu
Zip	yhju
Date of Birth	1935-04-18
Age(as of date)	87
Marital Status	Married
Member Identification Number	400001
HICN	
Phone Number	ytytguy
Cell Number	123
Alternate Contact Number	900
Email	tyutyu
Emergency Contact	12390
Phone Number	9090
Primary Care Physician	tthyn
Phone Number	12390
PCP Address	dfffyh
PCP City	tghtuty
PCP State	va

PCP Zip	1290
PCP County	hyg
Office ID	123
Office Name	cfhjy

1. Race

- ☐ Caucasian
 ☐ African American
 ☒ **Asian**
- ☐ Latino
 ☐ Native American
 ☐ Native Hawaiian or other Pacific Islander
- ☐ Alaskan Native
 ☐ Other

comments

asian

Patient's Ethnicity

- ☐ Hispanic
 ☐ Non-Hispanic
 ☐ Other Ethnicity
- ☒ **Prefer not to say**

comments

hispanic

Preferred language

- ☐ English
 ☒ **Other**

comments

english

↳ If other,

- ☐ African languages
 ☐ Arabic
 ☐ Chinese
- ☐ French
 ☐ French Creole
 ☐ German
- ☐ Greek
 ☐ Gujarati
 ☐ Hebrew
- ☐ Hindi
 ☐ Hungarian
 ☐ Italian
- ☐ Japanese
 ☐ Korean
 ☐ Persian
- ☐ Polish
 ☐ Portuguese
 ☒ **Russian**
- ☐ Scandinavian Languages
 ☐ Serbo-Croatian
 ☐ Spanish
- ☐ Tagalog
 ☐ Urdu
 ☐ Vietnamese
- ☐ Yiddish

Previously Documented Conditions

Covid Screening

In the last 14 days, have you:

Traveled internationally?	Yes	No
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Comment:

But for names usually we will not do validation mostly

Had known exposure to anyone diagnosed with Corona virus (COVID-19)	Yes	No
Comment: VERIFYING UPPER CASE LETTER		
Had close contact with someone who has traveled to a high risk area?	Yes	No
Comment: djdljs*#^\$*^638643		
Developed Fever?	Yes	No
Comment: djdljs*#^\$*^638643		
Developed Cough?	Yes	No
Comment: djdljs*#^\$*^638643		
Developed Flu like symptoms?	Yes	No
Comment: verifying lower case letter		
Developed Shortness of breath?	Yes	No
Comment: verifying lower case letter		

Screenings Needed

MICROALBUMIN

☒ Yes

☐ No

Status options

☒ Member refused

☐ Left kit

☐ Mail Kit direct to member

Reason member refused

☐ Member recently completed

☐ Scheduled to complete

☐ Member apprehension

☐ Not interested

☐ Other

Collected Sample

Microalbumin Test Barcode

Exam Date

Screening Result

Diagnosis

Comments

FOBT

☐ Yes

☒ No

comments

FOBT

A1C

☒ Yes

☐ No

comments

A1C

↳ **Status options**

- | | | |
|---|-----------------------------------|---|
| <input checked="" type="checkbox"/> Member refused | <input type="checkbox"/> Left kit | <input type="checkbox"/> Collected Sample |
| <input type="checkbox"/> Mail Kit direct to member | | |

↳ **Reason member refused**

- | | | |
|--|--|--|
| <input type="checkbox"/> Member recently completed | <input type="checkbox"/> Scheduled to complete | <input type="checkbox"/> Member apprehension |
| <input type="checkbox"/> Not interested | <input type="checkbox"/> Other | |

↳ **A1C Test Barcode**

↳ **Exam Date**

↳ **Screening Result**

↳ **Diagnosis**

↳ **Comments**

LDL

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

comments

LDK

↳ **Status options**

- | | | |
|---|-----------------------------------|---|
| <input checked="" type="checkbox"/> Member refused | <input type="checkbox"/> Left kit | <input type="checkbox"/> Collected Sample |
| <input type="checkbox"/> Mail Kit direct to member | | |

↳ **Reason member refused**

- | | | |
|--|--|--|
| <input type="checkbox"/> Member recently completed | <input type="checkbox"/> Scheduled to complete | <input type="checkbox"/> Member apprehension |
| <input type="checkbox"/> Not interested | <input type="checkbox"/> Other | |

↳ **LDL Test Barcode**

↳ **Exam Date**

↳ **Screening Result**

↳ **Diagnosis**

↳ **Comments**

RETINAL EYE EXAM

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

↳ **Status options**

- | | | |
|---|---|--|
| <input checked="" type="checkbox"/> Member refused | <input type="checkbox"/> Exam completed | <input type="checkbox"/> Environmental issue |
|---|---|--|

↳ **Reason member refused**

- | | | |
|--|--|--|
| <input type="checkbox"/> Member recently completed | <input type="checkbox"/> Scheduled to complete | <input type="checkbox"/> Member apprehension |
| <input type="checkbox"/> Not interested | <input type="checkbox"/> Other | |

↳ **Exam Date**

↳ **Screening Result**

↳ **Diagnosis**

Comments

DEXA

☒ Yes

☐ No

comments

Dexas

Status options

☒ Member refused

☐ Exam completed

☐ Environmental issue

Reason member refused

☐ Member recently completed

☐ Scheduled to complete

☐ Member apprehension

☐ Not interested

☐ Other

[Exam Date](#)

[Screening Result](#)

[Diagnosis](#)

[Comments](#)

PAD

☐ Yes

☒ No

comments

Pad only

Patient Summary



Assessors Comments :

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

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 :	2022-02-03T12:32
Time exam finished	2022-02-03T14:45
I accept the Disclosure Statement	<input checked="" type="checkbox"/>
Preventative Care checklist reviewed and left with member	<input checked="" type="checkbox"/>

Provider Signature	<div><div>shwe</div><div>Digitally signed by test clinicianFE, FNP 2022-02-03, 14:05</div></div>
Addendum	<div>Member saisfied online..</div> <div>Providing health care services means "the timely use of personal health services"chieve the best possible health outcomes"+_@##!(outcoe values \$%&*,.)[{}]</div> <div>Access to health + = / care may vary across countries, communities, and individuals, influenced by social and economic conditions as well as health policies.</div> <div>the free encyclopedia that anyone can edit. 6,558,572 articles</div> <div>23-11-2022</div>
Addendum Signature	<div><div>Wendy Swiney</div><div>Digitally signed by Admin Addendum, FNP 2022-11-23, 13:10</div></div>

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).