

HRA Form

Plan :	
Program :	
LOB :	
Region :	
Aligned :	
Health Plan :	Virginia Premier Healthcare Advantage
Member Name :	SHOUNE KEEL
Evaluator Name :	test clinicianFE, FNP
Assessment Type :	Health Risk Assessment
DOB :	1977-11-10
Evaluation Date :	07/21/2021 03:34 PM
Visit Type :	In Person

Demographics	
Name	SHOUNE KEEL
Gender	Male
Address	1845 NEW LINCOLN CIR,
City	HOPEWELL,
State	VA
Zip	238607220
Date of Birth	1977-11-10
Age(as of date)	43
Marital Status	
Member Identification Number	10099736
HICN	
Phone Number	8049302145
Cell Number	
Email	
Emergency Contact	
Phone Number	
Primary Care Physician	MOHIUDDIN, ABDUL
Phone Number	8045180780
PCP Address	46 DIAMOND DR, NORTH
PCP City	DINWIDDIE

PCP State	VA
PCP Zip	238037495
PCP County	
Office ID	
Office Name	DINWIDDIE HEALTH CARE LLC

Covid Screening

In the last 14 days, have you:

Traveled internationally?

Answer:

Had known exposure to anyone diagnosed with Corona virus (COVID-19)

Answer:

Had close contact with someone who has traveled to a high risk area?

Answer:

Developed Fever?

Answer:

Developed Cough?

Answer:

Developed Flu like symptoms?

Answer:

Developed Shortness of breath?

Answer:

Self-Assessment and Social History

13. Tobacco use

14. Alcohol Use

Answer:

Activities of Daily Living

19. Do you have any difficulty with the following activities?

A. Getting in or out of bed

Answer: No

B. Getting in or out of chairs

Answer: No

C. Toileting

Answer:

D. Bathing

Answer:

E. Dressing

Answer:

F. Eating

Answer:

G. Walking

Answer:

H. Going up or down stairs

Answer:

Medical History

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

Answer:

21. Are you currently seeing any specialists?

22. In the past 12 months how many times have you?

A. Seen your PCP

Answer:

B. Visited the Emergency Room

Answer:

C. Stayed in the hospital overnight

Answer:

D. Been in a nursing home

Answer:

E. Had Surgery

Answer:

24. In the past year have you received health services from any of the providers below:

Physical Therapist

Answer:

Occupational Therapist

Answer:

Dietician

Answer:

<b>Social Worker</b>	<i>Answer:</i>
<b>Pharmacist</b>	<i>Answer:</i>
<b>Speech Therapist</b>	<i>Answer:</i>
<b>Chiropractor</b>	<i>Answer:</i>
<b>Personal Care Worker (HHA, CNA, PCA)</b>	<i>Answer:</i>
<b>Meals on Wheels</b>	<i>Answer:</i>

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**25. In the past two years have you received any of the treatments below?**

<b>Chemotherapy</b>	<i>Answer:</i>
<b>Catheter Care</b>	<i>Answer:</i>
<b>Oxygen</b>	<i>Answer:</i>
<b>Wound Care</b>	<i>Answer:</i>
<b>Regular Injections</b>	<i>Answer:</i>
<b>Tube Feedings</b>	<i>Answer:</i>

<b>Family History</b>
<b>26. Family History</b>

Preventive Care	
27. In the past three years have you had?	
Screen	Answer
Colonoscopy	
Breast Exam/Mammography	
Cervical Screening	

Bone Density	
Prostate Exam/PSA	
If Diabetic Eye Exam	
If Diabetic Foot Exam	
If Diabetic Hgb A1c screen	
Lipid Panel	

Allergies / Medications

35. Allergies

Answer:

37. Chronic Use of

Answer:

38. Medication Compliance and Knowledge of Use and Disease

1. Do you ever forget to take your medicine?

Answer:

2. Do you sometimes not pay enough attention to your medication?

Answer:

3. Do you know the longterm benefit of taking your medicine as told to you by the doctor or pharmacist?

Answer:

4. When you feel better do you sometimes stop taking your medicine?

Answer:

5. Sometimes if you feel worse when you take your medicine do you stop taking it?

Answer:

6. Do you sometimes forget to refill your prescription on time?

Answer:

Review of Systems and Diagnoses

EYES

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

Answer:

EARS

Ear Problems (Hard of hearing, Deaf, Vertigo, Ear Infections)

Answer:

NOSE

Nose Problems (Nose Bleeds, Sinus infections, Other)

Answer:

MOUTH AND THROAT

Mouth and Throat Problems (Difficulty Chewing, Difficulty Swallowing, Bleeding Gums, Other )

Answer:

NECK

Neck Problems (parotid Disease, Carotid Stenosis, Other)

Answer:

RESPIRATORY

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

Answer:

CARDIOVASCULAR

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

Answer:

GASTROINTESTINAL

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

Answer:

NEURO-PSYCH

Neuro / Psych Problems (Stroke, Parkinson's disease, Seizures Paraplegia, Depression, Other)

Answer:

Neuro / Psych Problems (Stroke, Parkinson's disease, Seizures Paraplegia, Depression, Other)

GPCOG Score or MMSE Score

GPCOG Score

or MMSE Score

GENITOURINARY

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

Answer:

**MUSCULOSKELETAL**

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

Answer:

**INTEGUMENT**

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

Answer:

**ENDOCRINE**

**Endocrine Problems**

Answer:

**HEMATOLOGY / IMMUNOLOGY / INFECTIOUS DISEASE**

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

Answer:

**Pain**

**Vital Signs**

**Vital Signs**

Blood Pressure	
Pulse	
Respiratory Rate	
Temp	
Pulse Oximetry	
Pain Scale /10	

**BMI**

Comment:

Patients Height	
Patients Weight	

BMI	
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## Exam Review

## Screenings Needed

Screening Name	Member Eligible	Status	Barcode	Confirm Barcode	Screening Completed	Exam Date	Screening Result	Diagnosis	Comments
DIGITAL_RETINAL_EXAM	Select	Select			Select				
HBA1C	Select	Select			Select				
MICROALBUMIN	Select	Select			Select				
FOBT	No	Select			Select				
DEXA	N/A	Select			Select				
PAD	Select	Select			Select				
LDL	No	Select			Select				

## Mini-Cog

Word List Version	
Person's Answers	
Word Recall	
Clock Draw	
Total Score	

## Home Safety & Personal Goals

**41. Home Safety**

a. Do you have obstacles in the house, loose small rugs or objects on the floor that could cause tripping?



Answer:

b. Do you have electrical cords running across floors, in doorways or under a rugs?

Answer:

c. Do you have no slip mats on the shower floor or bath tub?

Answer:

d. Do have adequate lighting in hallways and on the stairs?

Answer:

e. Do you have handrails on staircases?

Answer:

f. Is your hot water heater set for a maximum of 120 degrees?

Answer:

g. Do you have smoke detectors on each level of the house and in all sleeping a rooms?

Answer:

h. Do you have carbon Monoxide detectors on each level of the house?

Answer:

i. Have used established an escape route in the event of fire?

Answer:

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


Answer:

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

Answer:

Patient Summary

Assessors Comments	
Member informed of acknowledgment	true
Date/Time of Service/ Evaluation :	
Time exam finished	
Provider Signature	<div><div>shwe</div><div><div>Digitally signed by test clinicianFE, FNP 2021-07-21, 15:41</div></div></div>
Addendum	
Member Acknowledgment	I have been advised by the evaluator and understand that the services performed by the evaluator are limited to the



FOCUSCARE

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	<p>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</p>
Disclosure Statement	<div><div><p>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.</p></div><div><p>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.</p></div><div><p>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.</p></div><div><p>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.</p></div><div><p>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.</p></div><div><p>Focus Care may be required to release your personal health information, without your permission, by law. including statutes, regulations, or valid court orders.</p></div><div><p>Focus Care will obtain your permission to use or release your personal health information for any other reason.</p></div><div><p>Do you have any questions about this information?</p></div></div>

	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?