

HRA Form

| | |
|-------------------|-----------------------------------|
| Health Plan : | Optima Health |
| Member Name : | ROSE M SUMMERVILLE |
| Evaluator Name : | Temeka Gillespie, FNP |
| Assessment Type : | Health Risk Assessment |
| DOB : | 1957-10-05 |
| Evaluation Date : | 2021-7-17 10:00 AM |
| Visit Type : | Virtual: Video & Audio Capability |

Demographics

| | |
|------------------------------|------------------------------|
| Plan | OHP - OPTIMA |
| Program | MEDICARE |
| LOB | DSNP |
| Name | ROSE M SUMMERVILLE |
| Gender | Female |
| Address | 209 POPLAR AVE |
| City | NORFOLK |
| State | VA |
| Zip | 23523-9998 |
| Date of Birth | 1957-10-05 |
| Age(as of date) | 63 |
| Marital Status | Divorced |
| Member Identification Number | 900035473*01 |
| HICN | |
| Phone Number | 757/816-4808 |
| Cell Number | 757/816-4808, |
| Alternate Contact Number | 757/816-4808, |
| Email | |
| Emergency Contact | Roschonda Ames |
| Phone Number | 7578164808 |
| Primary Care Physician | ISMAELI-CAMPBELL, ATTIYAH MD |
| Phone Number | 757/983-1777 |
| PCP Address | 213 RIVER WALK PKWY STE 101 |
| PCP City | CHESAPEAKE |
| PCP State | VA |

| | |
|-------------|--------|
| PCP Zip | 23320 |
| PCP County | |
| Office ID | 700507 |
| Office Name | |

1. Race

- | | | |
|---|---|--|
| <input type="checkbox"/> Caucasian | <input checked="" type="checkbox"/> African American | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Latino | <input type="checkbox"/> Native American | <input type="checkbox"/> Native Hawaiian or other Pacific Islander |
| <input type="checkbox"/> Alaskan Native | <input type="checkbox"/> Other | |

Patient's Ethnicity

- | | | |
|--|---|--|
| <input type="checkbox"/> Hispanic | <input checked="" type="checkbox"/> Non-Hispanic | <input type="checkbox"/> Other Ethnicity |
| <input type="checkbox"/> Prefer not to say | | |

2. Preferred language

- | | |
|--|--------------------------------|
| <input checked="" type="checkbox"/> English | <input type="checkbox"/> 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

3. How much school have you completed?

- | | | |
|---|--|--|
| <input type="checkbox"/> Less than 3rd grade | <input type="checkbox"/> Completed 3rd grade | <input type="checkbox"/> Completed 8th grade |
| <input checked="" type="checkbox"/> Completed 12th grade | <input type="checkbox"/> Attended College | |

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

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

comments

Currently having difficulty due to some emotional or cognitive decline

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

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

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

- ☒ **Not at All Confident** ☐ Not Very Confident ☐ Confident
☐ Very Confident

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

- ☐ Excellent ☐ Good ☒ **Fair**
☐ Poor

8. 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

9. Where do you currently live?

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

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

- ☒ **Yes** ☐ No

11. Who do you currently live with?

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

comments

Friend/Caretaker

12. Are you currently a caregiver for someone?

- ☐ Yes ☒ **No**

13. Tobacco use

- ☐ Current ☐ Former ☒ **Never**

14. Alcohol Use

- ☐ Current ☐ Former ☒ **Never**

15. Do you or have you used recreational drugs or pain medication?

- ☐ Yes ☒ **No**

16. Do you have a Healthcare Proxy?

☒ **Yes**
☐ **No**
☐ **Don't Know**

↳ **Name**

Roschanda Ames

↳ **Relationship**

Daughter

17. Do you have a Durable Power of Attorney?

☒ **Yes**
☐ **No**
☐ **Don't Know**

↳ **Name**

Loschonda Ames

↳ **Relationship**

Daughter

18. 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**

Activities of Daily Living

19. 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 |

Comment: Able to bath self but needs some assistance

| | | | |
|-------------|----|----------------|-----------------|
| 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**

| | | | |
|----------------------------|----|----------------|-----------------|
| 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

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

☐ None

☐ Cane

☒ **Wheel Chair**

☐ Bed Pan

☒ **Walker**

☐ Bedside Commode

☐ Other

☐ Prosthesis

☐ Urinal

21. Are you currently seeing any specialists?

☒ **Yes**

☐ No

| Medical Specialty | Specialist | For |
|-------------------|------------|------------------|
| Oncologist | | Multiple Myeloma |
| Other | Ortho | OA-Hips |

22. 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 |

[If one or more, describe](#)

July 2021--Evaluation of Chest pain (no findings)

| | | | | | | |
|-------------------------------------|------|---|---|---|---|-----------|
| 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 |

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

☒ **Yes**

☐ No

[Describe](#)

2013--Hypertensive Crisis

24. 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 |

25. In the past two years 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

26. Family History

☒ Yes

☐ No

| Family Member | Medical Condition | Cause of Death |
|---------------|--------------------|----------------|
| Mother | HTN, Breast Cancer | |

Preventive Care

27. In the past three years have you had?

| Screen | Answer |
|----------------------------|----------------|
| Colonoscopy | No |
| Breast Exam/Mammography | Yes |
| Cervical Screening | Yes |
| Bone Density | No |
| Prostate Exam/PSA | Not Applicable |
| If Diabetic Eye Exam | Not Applicable |
| If Diabetic Foot Exam | Not Applicable |
| If Diabetic Hgb A1c screen | Not Applicable |
| Lipid Panel | Yes |

28. Last colonoscopy if more than 2 years ago

☒ 3 – 5 years ago

☐ 6 – 10 years ago

☐ > 10 years ago

☐ Never

☐ Don't know

29. Screen for abnormal glucose / diabetes - age 40 - 70

☒ Yes

☐ No

☐ NA

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

☐ Yes

☐ No

☒ NA

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

☐ Yes

☐ No

☐ NA

comments

Unknown

32. Do you get Flu Vaccine each year?

☐ Yes ☒ No

33. Have you been vaccinated for Pneumonia?

☐ Yes ☒ No

34. Have you been vaccinated for Herpes Zoster?

☐ Yes ☒ No

Allergies / Medications

35. Allergies

☐ Yes ☒ No

Medications

| Diagnoses | Label Name | Dose / Units | Route | Frequency | Prescribing Physician | Status | |
|--------------------|--------------|--------------|---------------|-----------|-----------------------|--------|------------|
| Insomnia | ZOLPIDEM | TAB 10MG | PO = By Mouth | HS | Palliative Care | Taking | Not Taking |
| pain | PREGABALIN | CAP 75MG | PO = By Mouth | QD | Palliative Care | Taking | Not Taking |
| Pain | OXYCODONE | TAB 80MG ER | PO = By Mouth | PRN | Palliative Care | Taking | Not Taking |
| Pain med Tx | NARCAN | SPR | N = Nasal | PRN | Palliative Care | Taking | Not Taking |
| pain | TRAMADOL HCL | TAB 50MG | PO = By Mouth | PRN | Palliative Care | Taking | Not Taking |
| Anxiety | ALPRAZOLAM | TAB 0.5MG | PO = By Mouth | PRN | Palliative Care | Taking | Not Taking |
| Pain | DICLOFENAC | GEL 0.01 | T = Topical | PRN | Palliative Care | Taking | Not Taking |
| Hx DVT | XARELTO | TAB 20MG | PO = By Mouth | QD | Palliative Care | Taking | Not Taking |
| HTN | LOSARTAN/HCT | TAB 100-25 | PO = By Mouth | QD | Palliative Care | Taking | Not Taking |
| Depression/Anxiety | DULOXETINE | CAP 30MG | PO = By Mouth | QD | Palliative Care | Taking | Not Taking |

36. Over the Counter Medications / Supplements

☐ Yes ☒ No

37. Chronic Use of

☐ None

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

38. 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 |

Review of Systems and Diagnoses

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

☐ Yes ☒ No

Do you wear glasses or contacts?

☐ Yes ☒ No

Do you have problems seeing at night?

☐ 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

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

☐ Yes ☒ No

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

☒ Yes ☐ No

Diagnoses

- | | |
|---|--|
| <input type="checkbox"/> Abnormal Cardiac Rhythm | <input type="checkbox"/> Aneurysm |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Atrial Fibrillation |
| <input type="checkbox"/> Cardio – Respiratory Failure / Shock | <input type="checkbox"/> Cardiomyopathy |
| <input checked="" type="checkbox"/> Congestive Heart Failure | <input checked="" type="checkbox"/> Deep Vein Thrombosis |
| <input checked="" type="checkbox"/> Hyperlipidemia | <input checked="" type="checkbox"/> Hypertension |
| <input type="checkbox"/> Ischemic Heart Disease (CAD) | <input type="checkbox"/> Myocardial Infarction |

☐ Peripheral Vascular Disease

☐ Pulmonary Hypertension

☐ Valvular Disease

☐ Other

Congestive Heart Failure

Describe

☒ Active

☐ History of

☐ Rule out

Supported by

☐ Ejection fraction

☐ Cardiomegaly

☐ Orthopnea

☐ DOE

☐ PND

☐ S3

☒ Medications

☒ Peripheral edema

☐ Other

Describe

☐ Diastolic

☐ Systolic

☒ Unknown

Secondary to Hypertension

☒ Yes

☐ No

Is patient on an ACE or ARB

☒ Yes

☐ No

comments

Tx Lisinopril-HCT

Is patient on a Beta Blocker

☐ Yes

☒ No

Deep Vein Thrombosis

Describe

☐ Acute

☒ Chronic

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

☒ Physical findings

☒ Use of anticoagulation

☒ Vascular studies

☐ Vena Cava filter

☐ Edema

☐ Other

comments

Tx Xalerto

Use of anticoagulation

Describe

☐ Prophylactic

☒ Therapeutic

Persistent for three months or more

☒ Yes

☐ No

Hyperlipidemia

Describe

☐ Active

☒ History of

☐ Rule out

Supported by

☒ Lab results

☐ Medication

☐ Other

Is patient on Statin

☐ Yes

☒ No

comments

No current Tx

Hypertension

Describe

☒ Active

☐ History of

☐ Rule out

comments


Tx Lisinopril-HCT

Supported by

☐ Physical Exam

☒ Medications

☐ Symptoms

 FOCUSCARE

9

☐ Other
☒ Adequately controlled
☐ Yes ☐ No ☒ UnKnown

History of Chest Pain
☐ Yes ☒ No

History of Intermittent Claudication
☐ Yes ☒ No

Implanted Pacemaker
☐ Yes ☒ No

Implanted Defibrillator
☐ Yes ☒ No

Do you have abnormal heart beats?
☐ Yes ☒ No

Does your heart race?
☐ Yes ☒ No

Do you sleep on more then one pillow?
☐ Yes ☒ No

have you ever have fluid in your lungs?
☐ Yes ☒ No

Do your legs or ankles swell up?
☒ Yes ☐ No

Do you follow a special diet?
☐ Yes ☒ No

Do you have headaches?
☐ Yes ☒ No

Do you feel light headed when you stand up?
☐ Yes ☒ No

Gastrointestinal Problems (Ulcer, Reflux, Hiatal Hernia, Colitis, Other)
☐ Yes ☒ No

Bowel Movements
☐ Normal ☒ Abnormal
☒ If abnormal
☒ Constipation ☐ Diarrhea ☐ Bowel Incontinence

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

Dementia

Describe

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

Supported by

- | | | |
|---|---|------------------------------|
| <input type="checkbox"/> Behavioral changes | <input type="checkbox"/> Mental testing | <input type="checkbox"/> MRI |
| <input checked="" type="checkbox"/> Functional changes | <input type="checkbox"/> Other | |

comments

Memory issues since Chemo/radiation

Type of Dementia

- | | | |
|-----------------------------------|--|---|
| <input type="checkbox"/> Vascular | <input type="checkbox"/> Alzheimer's disease | <input checked="" 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 type="checkbox"/> PHQ 2 / 9 | <input checked="" type="checkbox"/> Use of antidepressant medication |
|---|------------------------------------|---|

- ☐ Other

comments

Tx Cymbalta

Major

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

Generalized Anxiety Disorder

Describe

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

Supported by

- | | | |
|---|--------------------------------|---|
| <input checked="" type="checkbox"/> Symptoms | <input type="checkbox"/> GAD 7 | <input checked="" type="checkbox"/> Antianxiety medication |
|---|--------------------------------|---|

- ☐ Other

comments

Tx Cymbalta

Insomnia

Describe

☒ Active

☐ History Of

☐ Rule out

Supported by

☐ Medication

☒ Symptoms

☒ History

☐ Other

comments

Tx Ambien

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 headaches

☐ 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 follow a special diet?

☐ Yes

☒ No

Do you have any weakness or deformity in your arms or legs that limits your ability to get around or do what you want to do?

☒ Yes

☐ No

Do you have trouble swallowing your food?

☐ Yes

☒ No

Do you have trouble making people understand you when you speak?

☐ Yes

☒ No

Do you trouble understanding what people say to you?

☐ Yes

☒ No

Do your hands shake?

☐ Yes

☒ No

Do you have convulsions and seizures?

☐ Yes

☒ No

Do you have trouble with your memory?

☒ Yes

☐ No

Do you have trouble finding words?

☐ Yes

☒ No

Do you have trouble sleeping?

☒ Yes

☐ No

Have you lost your appetite

☐ Yes

☒ No

Do you hear voices or see things that other people do not

☐ Yes

☒ No

Do you have highs and lows

☒ Yes ☐ No

Do you ever feel like someone is out to get you

☐ Yes ☒ No

How often do you go out to meet with family or friends

☐ Often ☒ Sometimes ☐ Never

GPCOG Score or MMSE Score

| GPCOG Score | or MMSE Score |
|-------------|---------------|
| | |

If GPCOG or MMSE is not done, is

↳ Patient oriented to person

☒ Yes ☐ No

↳ Patient oriented to place

☒ Yes ☐ No

↳ Patient oriented to time

☐ Yes ☒ No

↳ Recall

☐ Good ☒ Poor

↳ Patient describes recent news event

☐ Yes ☒ Partially ☐ No

Affect

☒ Normal ☐ Abnormal

Over the past 2 weeks, how often have you been bothered by any of the following problems?

| | | | | |
|---|------------|--------------|-------------------------|------------------|
| Little interest or pleasure in doing things | Not at all | Several Days | More than half the days | Nearly every day |
| Feeling down, depressed or hopeless | Not at all | Several Days | More than half the days | Nearly every day |

PHQ 2 Score

☒ < 3 ☐ 3 or more

Speech

☐ Normal ☐ Slurred ☒ Aphasic
☐ Apraxia

comments

Speech disturbances since Chemo/Radiation (2012)

Finger to Nose

☐ Normal ☐ Abnormal

comments

Virtual, limited exam

Heel (Shin) to Toe

☐ Normal

☐ Abnormal

comments

Virtual, limited exam

Thumb to Finger Tips

☐ Normal

☐ Abnormal

comments

Virtual, limited exam

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)

comments

Legs weak, need support of cane or walker

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

☐ Yes

☒ No

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

☐ Yes

☒ No

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

☐ Yes

☒ No

Endocrine Problems

☐ Yes

☒ No

Have you lost weight in the past 6 months?

☒ None

☐ 5lbs

☐ 10lbs

☐ 15lbs

☐ More than 15lbs

☐ 10% of your weight (calculated by assessor)

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

☒ Yes

☐ No

Diagnoses

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

Describe

- ☒ Active
- ☐ History of
- ☐ Rule out

Supported by

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

- ☐ Other

Etiology

- ☐ Iron deficiency
- ☐ Hemolysis
- ☐ Blood loss
- ☐ Other
- ☐ Pernicious
- ☐ Aplastic
- ☐ Chronic Disease
- ☐ Kidney disease
- ☐ Chemotherapy
- ☐ Folate Deficiency

If yes, Patient on

- ☐ Iron
- ☐ B 12
- ☐ Folic Acid
- ☐ Blood Transfusions
- ☐ Other

comments

No current Iron supplement

Multiple Myeloma

Describe

- ☐ Active
- ☒ History of
- ☐ Rule out

Supported by

- ☒ Symptoms
- ☒ Lab tests
- ☐ Other

Easy bruising or abnormal bleeding

- ☐ Yes
- ☒ No

Long term anticoagulation use

- ☐ Yes
- ☒ No

Cancer

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

Describe

- ☐ Active
- ☒ History of
- ☐ Rule out

Supported by

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

Type

- | | | |
|--------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Brain | <input type="checkbox"/> Head | <input type="checkbox"/> Neck |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Lung | <input type="checkbox"/> Esophagus |
| <input type="checkbox"/> Stomach | <input type="checkbox"/> Liver | <input type="checkbox"/> Pancreas |
| <input type="checkbox"/> Colon | <input type="checkbox"/> Rectum | <input type="checkbox"/> Kidney |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Ovaries | <input type="checkbox"/> Uterus |
| <input type="checkbox"/> Prostate | <input type="checkbox"/> Bone | <input type="checkbox"/> Blood |
| <input type="checkbox"/> Lymph Nodes | <input type="checkbox"/> Skin | <input checked="" type="checkbox"/> Other |

Other

Describe

Multiple Myeloma

Specific type/s

Unknown

Stage or Classification specific to the cancer

Unknown

Active treatment

- ☐ Yes ☒ No

comments

Previous Chemo & radiation Tx

History / Finding of Metastasis

- ☐ Yes ☒ No

Do you see a specialist?

- ☒ Yes ☐ No

Provider

Oncologist follow ups Q1yr

Pain

Does the patient experience pain?

- ☒ Yes ☐ No

Is the Pain Acute?

- ☐ Yes ☒ No

Is the Pain Chronic?

- ☒ Yes ☐ No

Describe

☒ Active

☐ History of

☐ Rule out

Where

Numbness/tingling in Legs

Do you take Methadone

- ☐ Yes ☒ No

What drug/s do you take for it

Lyrice, Oxycodone, Oxycontin

How bad is your pain on a scale of one to ten with one being very mild

and ten being severe

5/10 but up to 10/10

Is the Patient Undergoing Pain Management Planning?

☐ Yes ☒ No

Was the patient advised regarding the potential for dependence?

☒ Yes ☐ No

Is there any evidence of Maladaptive Behavior?

Tolerance?

☐ Yes ☒ No

Withdrawal?

☐ Yes ☒ No

Increased usage over a longer period that intended?

☐ Yes ☒ No

Desire or unsuccessful effort to cut down on use?

☐ Yes ☒ No

Excess time spent in activities to obtain the substance?

☐ Yes ☒ No

Continued use despite Doctor advice or patient knowledge of habituation?

☐ Yes ☒ No

Physical or Psychological Problem related to the substance use?

☐ Yes ☒ No

Vital Signs

Vital Signs

| Blood Pressure | | Pulse | Respiratory Rate | Temp | Pulse Oximetry | Pain Scale /10 |
|----------------|--------|-------|------------------|------|----------------|----------------|
| (mmHG) | (mmHG) | (bpm) | | | | 5 |

BMI

comments

As per daughter, Weight unknown

| Patients Height | | Patients Weight | Calculate BMI |
|-----------------|----------|-----------------|---------------|
| 5 (Feet) | 5 (Inch) | (lbs) | |

- ☐ Obesity (BMI 30 – 34.9)
 ☐ Moderate Obesity (BMI 35 – 39.9)
 ☐ Morbid Obesity (BMI = or > 40)
 ☐ Malnutrition (BMI < 18.5)

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 |
| Comment: Virtual, limited exam | | |

Eyes

| | | |
|-------------------------------------|--------|----------|
| Inspection of conjunctiva and lids: | Normal | Abnormal |
| Examination of pupils and irises: | Normal | Abnormal |
| Comment: Virtual, limited exam | | |

Ears, Nose, Mouth and Throat

| | | |
|---------------------------------------|--------|----------|
| External Inspection of ears and nose: | Normal | Abnormal |
| Otoscopic examination: | Normal | Abnormal |
| Comment: Virtual, limited exam | | |

| | | |
|--|--------|----------|
| Assessment of hearing: | Normal | Abnormal |
| Inspection of nasal mucosa, septum and trubينات: | Normal | Abnormal |
| Inspection of lips, teeth and gums: | Normal | Abnormal |
| Examination of oropharynx: | Normal | Abnormal |

Neck

| | | |
|--------------------------------|--------|----------|
| Examination of neck: | Normal | Abnormal |
| Examination of thyroid: | Normal | Abnormal |
| Comment: Virtual, limited exam | | |

Pulmonary

| | | |
|-----------------------------------|--------|----------|
| Assessment of respiratory effort: | Normal | Abnormal |
| Percussion of chest: | Normal | Abnormal |
| Comment: Virtual, limited exam | | |

| | | |
|------------------------|--------|----------|
| Palpation of chest: | Normal | Abnormal |
| Auscultation of lungs: | Normal | Abnormal |

Cardiovascular

| | | |
|--------------------------------|--------|----------|
| Palpation of heart: | Normal | Abnormal |
| Comment: Virtual, limited exam | | |

| | | |
|------------------------|--------|----------|
| Auscultation of heart: | Normal | Abnormal |
| Carotid Arteries: | Normal | Abnormal |

| | | |
|--------------------------------------|--------|----------|
| Abdominal Aorta: | Normal | Abnormal |
| Pedal Pulses: | Normal | Abnormal |
| Examination of Arterial Pulses: | Normal | Abnormal |
| Examination of Edema / Varicosities: | Normal | Abnormal |

Lymphatic

| | | |
|------------------------------------|--------|----------|
| Palpation of cervical nodes (neck) | Normal | Abnormal |
|------------------------------------|--------|----------|

Comment: Virtual, limited exam

| | | |
|--|--------|----------|
| 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 |
|----------------------------------|--------|----------|

Comment: Weak gait, need support of cane or walker

| | | |
|--|--------|----------|
| 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 |
| Palpation of skin and subcutaneous tissue: | Normal | Abnormal |

Comment: Virtual, limited exam

Neurologic

Indicate specific cranial nerve tested

CN (3, 4, 6), (5, 7, 8, 10, 11, 12)--appears WNL (virtual)

Indicate cranial nerve deficits found

Virtual, limited exam

| | | |
|--------------|--------|----------|
| Romberg Test | Normal | Abnormal |
|--------------|--------|----------|

Comment: Virtual, limited exam

| | | |
|---------------------------|--------|----------|
| Examination of reflexes: | Normal | Abnormal |
| Examination of sensation: | Normal | Abnormal |
| Coordination: | Normal | Abnormal |

Comment: Need support of cane or walker

Diabetes

| | | |
|------------|--------|----------|
| Foot Exam: | Normal | Abnormal |
|------------|--------|----------|

Comment: N/A

Psychiatric

| | | |
|---|--------|----------|
| Description of patient's judgement / insight: | Normal | Abnormal |
|---|--------|----------|

Comment: Some memory/cognitive issues

| | | |
|--|--------|----------|
| Orientation of person, place and time: | Normal | Abnormal |
| Recent and remote memory: | Normal | Abnormal |
| Mood and affect: | Normal | Abnormal |

Screenings Needed

| Screening Name | Member Eligible | Status | Barcode | Confirm Barcode | Screening Completed | Exam Date | Screening Result | Diagnoses | Comments |
|----------------------|-----------------|--------|---------|-----------------|---------------------|-----------|------------------|-----------|------------------------|
| DIGITAL_RETINAL_EXAM | Yes | Select | | | No | | | | Virtual, no screenings |
| HBA1C | Yes | Select | | | No | | | | |
| MICROALBUMIN | Yes | Select | | | No | | | | |
| FOBT | Yes | Select | | | No | | | | |
| DEXA | N/A | Select | | | No | | | | |
| PAD | Yes | Select | | | No | | | | |
| LDL | No | Select | | | No | | | | |

Mini-Cog

39. Mini- Cog (see attached sheet)

comments No Mini-Cog, memory issues associated previous Chemo/Radiation Tx

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 : 1

Person's Answers: --

| | | |
|---------------|----------|---|
| Word Recall : | 0 Points | 1 point for each word spontaneously recalled without cueing. Home Safety Yes |
| Clock Draw : | 0 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 : | 0 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. |

Home Safety & Personal Goals

40. In the past year how many times have you Fallen?

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

41. 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 |

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

No specific areas of improvement at this time

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

No specific areas of improvement at this time

44. Have you ever physically or felt emotionally abused by someone

- ☐ Yes
 ☒ No

45. Feeling like harming others or yourself

☐ Yes ☒ No

46. Are you afraid of anyone or is anyone hurting you?

☐ Yes ☒ No

Patient Summary


Assessors Comments :

Annual Health Assessment, responses provided by Roschonda (daughter). She has memory & speech issues since s/p Chemo & radiation Tx. She's followed by Palliative Care services , they come into home for frequent visits & Tx plan. She is reportedly feeling well overall, stable on current Tx & denies any new complaints/concerns/complications.

**Provided counseling for Preventive Health maintenance recommendations
 **Virtual visit, therefore some blank responses due to limited assessment info.
 **Verification: Name/DOB

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 : | 2021-07-17T10:10 |
| Time exam finished | 2021-07-17T10:53 |
| I accept the Disclosure Statement | <input checked="" type="checkbox"/> |
| Consented to Video chat | <input checked="" type="checkbox"/> |
| Provider Signature | <div> <div>Temeka Gillespie</div> <div>  <div>Digitally signed by Temeka Gillespie, FNP 2021-07-26, 03:13</div> </div> </div> |
| 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?