

CONFIDENTIAL INFORMATION

From :

c/o Focus Care
500 West Cummings Park
Suite 2700
Woburn, MA 01801

To :

SAN-MARINA, ANDREI MD
STE A 940 GENERAL BOOTH BLV
23451

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c/o Focus Care

500 West Cummings Park Suite 2700| Woburn, MA 01801

REBECCA B CONTRERAS

c/o Focus Care

500 West Cummings Park Suite 2700| Woburn, MA 01801

STE A 940 GENERAL BOOTH BLV

VIRGINIA BEACH

2022-05-26

SAN-MARINA, ANDREI MD

Through our partnership with Focus Care, your patient, covered through Optima Health, recently received a health visit by one of Focus Care's clinicians. Enclosed is a summary of the visit results for:

REBECCA B CONTRERAS

900038993*01

This summary contains an environmental assessment, a summary of existing diagnoses, a list of current medications that may help you gain additional insight into your patient's health, as well as preventive and chronic care recommendations. Please discuss the findings with your patient at their next appointment or reach out to them for urgent concern.

If you have any questions, please contact Focus Care at 1-800-371-3338 (TTY: 711) Monday through Friday, 8:30 a.m. to 9:00 p.m.

Sincerely,

Your Vital Signs

| | | | | | |
|----------------|-----------------------|-------|-----|------------------|--|
| Blood Pressure | /[object Object] mmHG | Pulse | bpm | Respiratory Rate | |
|----------------|-----------------------|-------|-----|------------------|--|

Patient Assessment Summary

Name : REBECCA B CONTRERAS
Date of Birth : 1976-04-07
Evaluator Name : undefined
Gender : Female
Lob : DSNP
Email :

Age : 45
Member ID : 900038993*01
Date : undefined
Address : 4605 LIND ST,NORFOLK,VA
Marital Status : Single
Phno : 336/997-3495,336/997-3495,

| | | | | | |
|------|------|-----------------|---|-----------------|-----|
| Temp | | Pulse Oximetry | | Pain Scale /10 | 7 |
| Age | 45 | Patients Height | 5 | Patients Weight | 203 |
| BMI | 30.9 | | | | |

Your Screenings

| Screening Name | Screening Completed | Exam Date | Screening Result | Diagnosis | Comments |
|--------------------------|---------------------|-----------|------------------|-----------|----------|
| DIGITAL_RETINAL_EXA M | Select | | | | |
| HBA1C | Select | | | | |
| MICROALBUMIN | Select | | | | |
| FOBT | Select | | | | |
| DEXA | Select | | | | |
| PAD | Select | | | | |
| Peak Flow Meter | Select | | | | |

Allergies

Answer: yes

| Substance | Reaction |
|-----------|-------------|
| STADOL | ANAPHYLAXIS |

Your Medications

| Diagnoses | Label Name | Dose / Units | Route | Frequency | Prescrib ing Physicia n | Status |
|-----------|--------------|--------------|---------------|-----------|----------------------------------|--------|
| ANXIETY | CLONAZEPAM | TAB 0.5MG | PO = By Mouth | PRN | UNK | Taking |
| SLEEP | TRAZODONE | TAB 50MG | PO = By Mouth | HS | UNK | Taking |
| BIPOLAR | LITHIUM CARB | CAP 300MG | PO = By Mouth | TID | UNK | Taking |
| SCIATICA | GABAPENTIN | TAB 300MG | PO = By Mouth | QID | UNK | Taking |
| OCD | FLUVOXAMINE | TAB 100MG | PO = By Mouth | BID | UNK | Taking |

Over the Counter Medications / Supplements

Answer: No

Race

Answer: Caucasian

Preferred language

Answer: English

Patient Assessment Summary

| | | | |
|----------------|-----------------------|----------------|------------------------------|
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| Date of Birth | : 1976-04-07 | Member ID | : 900038993*01 |
| Evaluator Name | : undefined | Date | : undefined |
| Gender | : Female | Address | : 4605 LIND ST,NORFOLK,VA |
| Lob | : DSNP | Marital Status | : Single |
| Email | : | Phno | : 336/997-3495,336/997-3495, |

Diagnoses under Chronic Care Management

None

Care management related to self - assessment and psychosocial behaviors

Social service referral to further assess social support infrastructure

Who do you currently live with?**Alone**

Comment :

Do you have someone who can help if you are sick or have problems?**Yes**

Comment :

Counsel patient on the need for a Durable Power of Attorney.

Do you have a Durable Power of Attorney?**No**

Comment :

Counsel patient on the need for an Advance Directive.

Do you have an Advance Directive?**No**

Comment :

Counsel patient on the need for a Healthcare Proxy

Healthcare Proxy **Yes**

Comment :

Care management related to patient's activity levels

- Patient should be referred for a physical therapy evaluation related to ADL's.

Refer patient for a physical therapy evaluation

A. Getting in or out of bed : **No**

Refer patient for a physical therapy evaluation related to ADL's

B. Getting in or out of chairs : **No**

C. Toileting : **No**

D. Bathing : **No**

E. Dressing : **No**

F. Eating : **No**

G. Walking : **No**

H. Going up or down stairs : **No**

Care management related to past medical history

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

Answer: None

Comment:

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Email :

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Are you currently seeing any specialists?

Answer: Yes

| Medical Specialty | Specialist | For |
|-------------------|------------|-----------------|
| Neurologist | | BACK PAIN |
| Other | | SENTARA WT LOSS |

If no activities are checked as need some help or total help

Refer patient for a physical therapy evaluation : 4

A. Seen your PCP

Refer patient for a physical therapy evaluation related to ADL's

B. Visited the Emergency Room : 1

If one or more, describe

COVID

C. Stayed in the hospital overnight : 1

If one or more, describe

GASTRIC BYPASS

D. Been in a nursing home : None

E. Had Surgery : 1

If one or more, describe

GASTRIC BY PASS

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

Answer: No

- In the past year how many times have you Fallen?

Answer:

Social service referral to evaluate history of potential abuse

- Have you ever physically or felt emotionally abused by someone

Answer: Yes

Comment: IN THE PAST"

Have you lost weight in the past 6 months?

Answer:

Care management related to preventive care

Counsel patient on screening guidelines with relation to type of screens that are age and gender appropriate and timelines for those screens going forward.

| Screen | Answer |
|-------------------------|----------------|
| Colonoscopy | No |
| Breast Exam/Mammography | Yes |
| Cervical Screening | Yes |
| Bone Density | No |
| Prostate Exam/PSA | Not Applicable |

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| | |
|----------------------------|-----|
| If Diabetic Eye Exam | Yes |
| If Diabetic Foot Exam | Yes |
| If Diabetic Hgb A1c screen | Yes |
| Lipid Panel | Yes |

Care management related to diagnoses and symptoms

Family History

Answer: Yes

| Family Member | Medical Condition | Cause of Death |
|---------------|------------------------------|----------------|
| Father | DM, HTN, HYPERLIPIDEMIA, CVA | |
| Mother | DM, HTN, HYPERLIPIDEMIA | |

- In the past year how many times have you Fallen?

Answer:

Assessors Comments : BARIATRIC SURGERY- GASTRIC BYPASS 11/2021
NO HTN, GERD, HIGH CHOLESTEROL, STOPPED SMOKING 2018