

# CONFIDENTIAL INFORMATION

**From :**

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

**To :**

TOMIAK, WILLIAM M MD  
1375 W RIDGE ROAD  
24382

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

TIMOTHY J SHRADER

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

1375 W RIDGE ROAD  
WYTHEVILLE

2022-07-28

TOMIAK, WILLIAM M 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:

TIMOTHY J SHRADER  
900039820\*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 | 140/76 mmHG | Pulse |  | Respiratory Rate |  |
|----------------|-------------|-------|--|------------------|--|

# Patient Assessment Summary

|                |                     |                |  |
|----------------|---------------------|----------------|--|
| Name           | : TIMOTHY J SHRADER | Age            | : 56                                       |
| Date of Birth  | : 1965-08-06        | Member ID      | : 900039820*01                             |
| Evaluator Name | : undefined         | Date           | : undefined                                |
| Gender         | : Male              | Address        | : 114 WYE ROAD,WYTHEVILLE,VA               |
| Lob            | : DSNP              | Marital Status | : Single                                   |
| Email          | :                   | Phno           | : 276/227-0075,276/227-0075, 276/783-8157, |

|      |      |                 |   |                 |     |
|------|------|-----------------|---|-----------------|-----|
| Temp |      | Pulse Oximetry  |   | Pain Scale /10  |     |
| Age  | 56   | Patients Height | 5 | Patients Weight | 146 |
| BMI  | 23.6 |                 |   |                 |     |

## Your Screenings

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

## Allergies

Answer: yes

| Substance | Reaction     |
|-----------|--------------|
| kepra     | rash anxious |

## Your Medications

| Diagnoses | Label Name   | Dose / Units | Route         | Frequency | Prescribing Physician | Status |
|-----------|--------------|--------------|---------------|-----------|-----------------------|--------|
|           | NALTREXONE   | TAB 50MG     | Select        | Select    |                       | Taking |
|           | FISH OIL     | CAP 1000MG   | Select        | Select    |                       | Taking |
|           | THEREMS-M    | TAB          | PO = By Mouth | QD        |                       | Taking |
|           | SIMVASTATIN  | TAB 10MG     | PO = By Mouth | QD        |                       | Taking |
|           | OMEPRAZOLE   | CAP 40MG     | PO = By Mouth | QD        |                       | Taking |
|           | MUPIROCIN    | OIN 0.02     | Select        | Select    |                       | Taking |
|           | LISINOPRIL   | TAB 2.5MG    | PO = By Mouth | QD        |                       | Taking |
|           | GLIPIZIDE    | TAB 10MG     | PO = By Mouth | BID       |                       | Taking |
|           | HYDROXYZ PAM | CAP 25MG     | Select        | Select    |                       | Taking |
|           | ACETAMIN     | TAB 325MG    | Select        | Select    |                       | Taking |
|           | BUSPIRONE    | TAB 15MG     | PO = By Mouth | TID       |                       | Taking |
|           | RISPERIDONE  | TAB 0.25MG   | PO = By Mouth | BID       |                       | Taking |
|           | FLUOXETINE   | CAP 20MG     | Select        | Select    |                       | Taking |
|           | CLONIDINE    | TAB 0.1MG    | Select        | Select    |                       | Taking |

# Patient Assessment Summary

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Date of Birth : 1965-08-06 Member ID : 900039820\*01  
Evaluator Name : undefined Date : undefined  
Gender : Male Address : 114 WYE ROAD,WYTHEVILLE,VA  
Lob : DSNP Marital Status : Single  
Email : Phno : 276/227-0075,276/227-0075, 276/783-8157,

|  |                            |           |        |        |  |        |
|--|----------------------------|-----------|--------|--------|--|--------|
|  | VITAMIN C                  | TAB 500MG | Select | Select |  | Taking |
|  | CINNAMON                   | TAB 500MG | Select | Select |  | Taking |
|  | FLUTICASONE                | SPR 50MCG | Select | Select |  | Taking |
|  | VASELINE LIP               | OIN       | Select | Select |  | Taking |
|  | CLONIDINE HCL              |           | Select | Select |  | Taking |
|  | HYDROXYZINE<br>PAMOATE     |           | Select | Select |  | Taking |
|  | GLIPIZIDE                  |           | Select | Select |  | Taking |
|  | VITAMIN C                  |           | Select | Select |  | Taking |
|  | FLUOXETINE HCL             |           | Select | Select |  | Taking |
|  | BUSPIRONE<br>HYDROCHLORIDE |           | Select | Select |  | Taking |
|  | THEREMS-M                  |           | Select | Select |  | Taking |
|  | MUPIROCIN                  |           | Select | Select |  | Taking |
|  | CLONIDINE<br>HYDROCHLORIDE |           | Select | Select |  | Taking |
|  | FLUTICASONE<br>PROPIONATE  |           | Select | Select |  | Taking |
|  | NALTREXONE HCL             |           | Select | Select |  | Taking |
|  | ACETAMINOPHEN              |           | Select | Select |  | Taking |
|  | BUSPIRONE HCL              |           | Select | Select |  | Taking |
|  | VASELINE LIP<br>THERAPY    |           | Select | Select |  | Taking |

## Over the Counter Medications / Supplements

Answer:

### Race

Answer: **Caucasian**

### Preferred language

Answer: **English**

## Diagnoses under Chronic Care Management

### Active

#### Hyperlipidemia

Is patient on Statin

#### Hypertension

Adequately controlled

## Care management related to self - assessment and psychosocial behaviors

# Patient Assessment Summary

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Further assessment and questioning should be done to determine if patient's literacy level is adequate, limited or poor to determine the best method to communicate instructions and information to the patient.

How much school have you completed?**Less than 3rd grade**

Comment :

When you get written information at a doctor's office would you say it is?**Very difficult**

Comment :

When you read the instructions on a prescription bottle would you say that it is?**Very difficult**

Comment :

How confident are you in filling out medical forms by yourself?**Not at All Confident**

Comment :

Social service referral to further assess social support infrastructure.

During past 3 months has physical or emotional health limited social activities with family, friends, neighbors or groups?**Sometimes**

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 Durable Power of Attorney

Durable Power of Attorney **Yes**

Comment :

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## Care management related to patient's activity levels

- Patient should be referred for a physical therapy evaluation related to ADLs.

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 : **Need Some Help**

E. Dressing : **No**

F. Eating : **No**

G. Walking : **No**

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

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## Care management related to past medical history

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

Answer: None

Comment:

Are you currently seeing any specialists?

Answer: Yes

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| Medical Specialty | Specialist | For |
|-------------------|------------|-----|
|-------------------|------------|-----|

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 : None

C. Stayed in the hospital overnight : None

D. Been in a nursing home : None

E. Had Surgery : None

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

Answer: No

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

Answer: None

Social service referral to evaluate history of potential abuse

- Have you ever physically or felt emotionally abused by someone

Answer: No

Have you lost weight in the past 6 months?

Answer: None

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

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- In the past year how many times have you Fallen?  
Answer: **None**

Assessors Comments :