

ATTACHMENT B

Medicare Wellness Visit

Patient's Name: _____ D.O.B. ____ / ____ / ____ Exam Date: _____

Allergies to Meds: _____

Past personal illnesses, injuries, operations or diagnoses	Date	Hospitalized?

Tobacco use: YES NO If yes, (smoke or chew) How many per day? _____ Year you quit? _____

Alcohol Use: YES NO If yes, How many per day? _____ (Circle one) Beer, Wine or Hard liquor?

Drug Use: YES NO If yes, describe: _____

Prescriber	Medications, Supplements, Vitamins Name	Route (oral, topical. etc)	Dose	Frequency (ex. 1-2 times/day)

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Current list of patient's providers and suppliers:

NAME	SPECIALTY	REASON

FAMILY HISTORY:

DISEASE	SPECIFICITY	FAMILY MEMBER	CAUSE OF DEATH Yes or no?
Cancer			
Diabetes	Type 1 or Type 2		
Heart Disease			
Genetic			
Psych			
Other			

How many times/week do you exercise? _____ Duration? _____ Type? _____

HEARING LOSS SCREEN:

- 1 Do you have trouble hearing the TV or radio when others don't? YES NO
- 2 Do you have to strain or struggle to hear/understand conversations? YES NO
- 3 Do you wear hearing aides? YES NO

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FUNCTION SCREEN:

- 1 Do you need help with preparing meals, transportation, shopping, taking your meds, managing finances, or other activities of daily living? YES NO
- 2 Do you live alone? YES NO
- 3 Have there been any changes in your urination or bowel movements? YES NO
-Which one? _____

FALL SCREEN:

- 1 Have you had an injury from a fall in the past year? YES NO
If yes, when? _____
What was the cause? _____
- 2 Have you had more than one fall in the last year? YES NO

HOME SAFETY SCREEN:

- 1 Does your home have rugs, poor lighting, or a slippery Bathtub/shower? If yes, please circle which one YES NO
- 2 Does your home LACK grab bars in bathrooms, handrails on stairs or steps? If yes, please circle which one YES NO
- 3 Does your home LACK functioning smoke alarms? YES NO

ADVANCE CARE PLANNING:

We would like to discuss your wishes and Advanced Directives with you. Please sign below if you will permit us to have this conversation.

- 1 Patient Consent: "I consent to discuss end-of-life issues with my healthcare provider."

Patient/Guardian Signature

Date

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PREVENTATIVE SCREEN	MEDICARE COVERAGE	PREVIOUSLY TESTED DATE	SCHEDULED FOR SCREEN
Bone Mass measurement	Medicare Patients risk for developing osteoporosis		
Colorectal Cancer Screening(colonoscopy)	Medicare patients 50 and up		
Glaucoma/ Eye exam	Pts with diabetes, family hx of glaucoma		
Prostate Cancer Screening: PSA test	All Male patient 50 and older		
Screening Mammography:	All female patients 40 yrs and older		
Dental Exam			
VACCINES:	BRAND	DOSES	DATE
Covid			
Pneumococcal			
Influenza			
TD and Tdap			
RSV			
Shingrix			

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

Sign up Today!

Chronic Care Management for Medicare Patients

As a Medicare patient with two or more chronic conditions, you are eligible to receive additional support from our team.

How it Works

Better health is just a phone call away!

Our Care Coordinator will contact you by phone to develop a customized plan to manage your needs. Our goal is to assist you with receiving timely preventive care, medication management, effective transitions between providers, wellness goal setting and tracking, and overall support improving your health and well-being.

Medicare covers 80% of the monthly fee. Most supplemental plans cover the remaining 20% coinsurance. We can help you determine what insurance will cover. (Maximum out of pocket cost is \$8.00-\$10.00/month)

Talk to us today about getting started!