360 Comprehensive Assessment 2020

Member First Name

DOB (MM/DD/YYYY)

Last Name

DOS (MM/DD/YYYY)

Member ID

PCP NPI

Rendering Provider

Member's PCP

Location ☐ Private Residence ☐ PCP Practice ☐ Facility **Source** ☐ Patient ☐ Other (name & relationship) ____________

Reason for Exam: ☐ Annual 360 Comprehensive Assessment ☐ Other ____________

***Please note: All HEDIS QRS metrics are asterisked for your convenience**

Past Medical History *(this section intended only for those conditions without an active treatment plan)*: ☐ Reviewed and No Past Medical History

☐ CVA with no residual effect

☐ History of Cancer (specify):

Surgical History: ☐ Reviewed and No Surgeries

☐ Prior organ transplant (specify site/organ):

***Medications:** List all medications, including OTCs, with dosage and frequency. Or, attach printed, signed and dated list, and check here: ☐

☐ No Current Medications

☐ Medications Reviewed/Reconciled

☐ Difficulty taking or obtaining medication

Allergies: ☐ No known drug allergies

Family History: ☐ Reviewed and No Relevant History ☐ Unknown History

	Father	Mother	Children	Siblings	Grandparents
HTN	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐

	Father	Mother	Children	Siblings	Grandparents
High Lipids	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
____________	☐	☐	☐	☐	☐

Habits:

Tobacco Use: ☐ Yes ☐ No

☐ E-Cigarettes ☐ Current Smoker, PPD ____________

☐ Current Chew/Dip Use ☐ Previous Smoker, Year quit ____________

Alcohol Use:

☐ Yes, Drinks per day ________

☐ No

Alcohol usage a concern for you or others? ☐ Yes ☐ No

Social History:

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed

Lives: ☐ Alone ☐ Spouse ☐ Institutional ☐ Family ☐ Other: ____________

High Risk for Sexually Acquired Diseases including HIV: ☐ Yes ☐ No

Social/Difficulty handling finances: ☐ Yes ☐ No

Illicit Drug Use: ☐ Yes ☐ No

Current Physical Activity as compared to last year: ☐ More ☐ Less ☐ Same

Mobility: ☐ Independent ☐ Transfer difficulty ☐ Cane ☐ Walker ☐ Wheelchair ☐ Bedbound

Difficulty with bathing, toileting and dressing? ☐ Yes ☐ No

Difficulty with obtaining, preparing or eating food? ☐ Yes ☐ No

Vision: ☐ Normal ☐ Require glasses /contacts for routine vision

Hearing: ☐ Normal ☐ Hearing issues / hearing aid

Speech: ☐ Normal ☐ Impaired

How is your memory compared to last year? ☐ Better ☐ Worse ☐ Same

Difficulty driving ? ☐ Yes ☐ No

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Member Name: **DOB:** / / **DOS:** / /

***Fall Risk Screening:** (mark all that apply)

- ☐ Unable to perform exam b/c of ____________
- ☐ Diagnoses (3 or more existing)
- ☐ Prior history of falls within 3 months
- ☐ Incontinence
- ☐ Visual Impairment
- ☐ Impaired functional mobility
- ☐ Environmental Hazard
- ☐ Polypharmacy
- ☐ Pain affecting level of function
- ☐ Cognitive Impairment

TOTAL number of boxes marked ________

- ☐ Fall Risk (4 or more reported)

Depression Screening (18 + y/o)

☐ Screening not performed because the patient is unable to communicate/answer.

Have you felt depressed or down-and-out over the past 2 months?	☐ Yes	☐ No
Have you had a loss of interest in things that normally bring you pleasure?	☐ Yes	☐ No
Have you felt fatigued or had a loss of energy recently?	☐ Yes	☐ No

If two or more "Yes" then complete PHQ-9 document, and attach results to the 360 form:

☐ PHQ-9 form/Standard Screening Tool/Clinical Interview

PHQ-9 total score: ____________________

***Urinary Incontinence Screening**

During the last 3 months - have you leaked urine (even a small amount)? ☐ Yes ☐ No

If Yes, please distribute education material

Review of Systems	Negative	Positive/Findings
General	☐	
HEENT	☐	
Cardiac	☐	
Respiratory	☐	
GI	☐	
Musculoskeletal	☐	
Neurological	☐	
Skin	☐	
Psychiatric	☐	
Endocrine	☐	
Hematological	☐	
GU	☐	

THIS SECTION SHOULD NOT INCLUDE AN ACTIVE DIAGNOSIS.

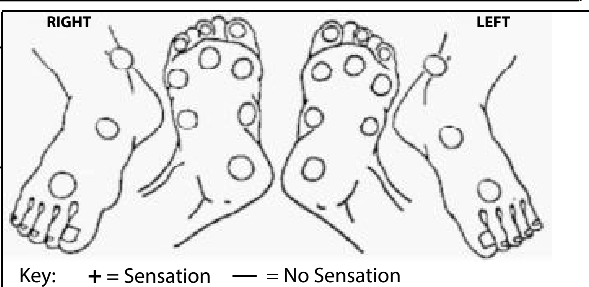
***Please assess the overall pain presence in the patient's day-to-day life:**
(all patients should have pain addressed, if no pain = 0, has pain = 1 - 10)

	0	1	2	3	4	5	6	7	8	9	10
*Pain Screening	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pain treatment plan: if no pain = N/A

☐ Meds	☐ PT	☐ Other
☐ Education	☐ Pain doctor	☐ N/A

Foot Exam: (Complete for diabetic patients and/or patients with neuropathic complaints)



Key: + = Sensation — = No Sensation

1. Ask the patient:

- ☐ Burning, tingling, numbness in feet
- ☐ Previous foot ulcer
- ☐ Pain or cramping in calf area during exercise
- ☐ None of these

2. Look at both feet:

☐ Infection	☐ Calluses or corns	☐ Nail disorders	☐ None of these
☐ Ulceration	☐ Skin breaks	☐ Foot deformity	

3. Check for foot pulse:	**Left**			**Right**		
Dorsalis pedis	☐ Normal	☐ Weak	☐ Absent	☐ Normal	☐ Weak	☐ Absent
Posterior Tibial	☐ Normal	☐ Weak	☐ Absent	☐ Normal	☐ Weak	☐ Absent
4. Test for neuropathy:	Left Monofilament	☐ Normal	☐ Abnormal	Right Monofilament	☐ Normal	☐ Abnormal

5. Complications due to diabetes: (check all that apply) ☐ None of these

☐ Peripheral neuropathy ☐ Peripheral vascular disease ☐ Ulcer ☐ Gangrene ☐ Amputation: date, side & level: ____________

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Member Name:	DOB: / /	DOS: / /

Vitals: *Ht (in): *Wt (lbs): *BMI: . Temp (F^0): . *BP: / HR: RR: Gender: ☐ Male ☐ Female

Comprehensive Exam	Normal	Abnormal/Findings (check box [norm] or abnormal exam for each [except deferred] required)
General	☐	
HEENT	☐	
Neck	☐	
Heart	☐	
Lungs	☐	
Breast	☐	☐ Deferred
Abdomen	☐	
Extremities	☐	
GU	☐	☐ Deferred
Musculoskeletal	☐	
Neurological	☐	
Skin	☐	
Psychiatric	☐	
Lymphatic	☐	
Hematologic	☐	☐ Deferred

Current Conditions: **Treatment Plan:**

Cardiovascular: ☐ **Reviewed and No Active Disease**	**Meds**	**Monitor**	**Diet**	**Labs**	**Referral**
☐ Myocardial infarction Date: ____________	☐	☐	☐	☐	☐
☐ Angina Pectoris	☐	☐	☐	☐	☐
☐ CAD ☐ CAD w/Angina Pectoris Vessel(s): ☐ native ☐ graft	☐	☐	☐	☐	☐
☐ Cardiomyopathy Type (specify): ☐ Presence of Internal Cardiac Defib	☐	☐	☐	☐	☐
☐ CHF: ☐ Left sided ☐ Right sided ☐ Diastolic ☐ Systolic ☐ Systolic **&** Diastolic	☐	☐	☐	☐	☐
☐ Pulmonary Hypertension ☐ Primary ☐ Secondary	☐	☐	☐	☐	☐
☐ Valvular disease ☐ Rheu ☐ Non-Rheu ☐ Mitral ☐ Aortic ☐ Pulmonic ☐ Tricuspid ☐ Stenosis ☐ Regurgitation	☐	☐	☐	☐	☐
☐ Hyperlipidemia If no statin, name of med ________ ☐ Mixed ☐ Other (specify): ________	☐	☐	☐	☐	☐
☐ Carotid artery stenosis Side: ☐ Right ☐ Left	☐	☐	☐	☐	☐
☐ Atrial Fibrillation ☐ Chronic ☐ Permanent ☐ Persistent	☐	☐	☐	☐	☐
☐ Sick Sinus Syndrome: ☐ w/ Pacemaker ☐ w/o Pacemaker	☐	☐	☐	☐	☐
☐ Tachycardia Type (specify): ____________	☐	☐	☐	☐	☐
☐ *Hypertension: Date of Diagnosis: ____________	☐	☐	☐	☐	☐
☐ HTN heart disease **w/**CHF *(note: add specific CHF above)* ☐ HTN heart disease **w/o** CHF	☐	☐	☐	☐	☐
☐ Hypertensive CKD *(note: add specific stage of CKD to renal section)*	☐	☐	☐	☐	☐
☐ Hypertensive Heart and CKD *(note: add specific stage of CKD to renal section)* ☐ **w/**CHF*(note: add specific CHF above)* ☐ **w/o** CHF	☐	☐	☐	☐	☐
☐ Peripheral Artery Disease	☐	☐	☐	☐	☐
☐ Vascular Disease ☐ Abd Aortic Aneurysm ☐ Thoracic Aortic Aneurysm	☐	☐	☐	☐	☐
☐ Other Diagnosis (specify): ____________	☐	☐	☐	☐	☐
Nutritional/Metabolic/Endocrine: ☐ **Reviewed and No Active Disease**	**Meds**	**Monitor**	**Diet**	**Labs**	**Referral**
☐ Protein Calorie Malnutrition ☐ Mild ☐ Moderate ☐ Cachexia	☐	☐	☐	☐	☐
☐ Overweight (BMI 25.0 - 29.9) ☐ Obesity (BMI 30 - 39.9) ☐ Morbid Obesity (BMI > 40) ☐ For BMI 35.0 - 39.9, document co-morbidity (i.e. HTN &/or DM) ____________	☐	☐	☐	☐	☐
☐ Hypothyroidism ► ☐ Acquired (post surgical) ☐ Hyperthyroidism	☐	☐	☐	☐	☐
☐ Pre-diabetes	☐	☐	☐	☐	☐
☐ Other Diagnosis (specify): ____________	☐	☐	☐	☐	☐

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Member Name: **DOB:** / / **DOS:** / /

Diabetes Mellitus: ***document all co-morbid manifestations*** ☐ **Reviewed and No Active Disease**	**Meds**	**Monitor**	**Diet**	**Labs**	**Referral**
☐ DM: ☐ Type 1 ☐ Type 2 ☐ Insulin ☐ Oral meds	☐	☐	☐	☐	☐
☐ Diabetes w/osteomyelitis	☐	☐	☐	☐	☐
☐ DM w/ Secondary Kidney Complications: ☐ CKD (note: include stage in renal section) ☐ Nephropathy	☐	☐	☐	☐	☐
☐ DM w/ Secondary Neurological Complications: ☐ Mononeuropathy ☐ Polyneuropathy ☐ Gastroparesis ☐ Other: ______	☐	☐	☐	☐	☐
☐ DM w/ Secondary Ophthalmic Complications: Side: ☐ Right ☐ Left ☐ Retinopathy: ☐ Proliferative ☐ Non-proliferative ☐ w/ Macular Edema ☐ Mild ☐ Moderate ☐ Severe ☐ Cataract ☐ Glaucoma	☐	☐	☐	☐	☐
☐ DM w/ Secondary Circulatory Complications: ☐ Peripheral Angiopathy/PVD ☐ w/ Gangrene ☐ w/o Gangrene	☐	☐	☐	☐	☐
☐ DM w/ Secondary Skin Complications: Side: ☐ Right ☐ Left ☐ Non-Pressure Chronic Ulcer ☐ Location (specify):	☐	☐	☐	☐	☐
☐ DM w/ Other Secondary Complications: ☐ Hypoglycemia ☐ Hyperglycemia	☐	☐	☐	☐	☐
☐ DM w/ Oral Complications: ☐ Periodontal ☐ Other: ______	☐	☐	☐	☐	☐
☐ DM w/arthropathy: ☐ Neuropathic ☐ Other: ______	☐	☐	☐	☐	☐

Respiratory: ☐ **Reviewed and No Active Disease**	**Meds**	**Monitor**	**Diet**	**Labs**	**Referral**
☐ Chronic Bronchitis: ☐ Obstructive ☐ Simple ☐ Mucopurulent ☐ Mixed	☐	☐	☐	☐	☐
☐ COPD: ☐ w/ Oxygen Dependence ☐ w/Exacerbation	☐	☐	☐	☐	☐
☐ Emphysema: ☐ Unilateral ☐ Panlobular ☐ Centrilobular ☐ Other: ______	☐	☐	☐	☐	☐
☐ Mesothelioma Location: ______	☐	☐	☐	☐	☐
☐ Asthma: ☐ Chronic Obstructive ☐ Intermittent ☐ Persistent ☐ Mild ☐ Moderate ☐ Severe	☐	☐	☐	☐	☐
☐ Bronchiectasis: ☐ w/ Exacerbation ☐ w/ Acute Lower Respiratory Infection	☐	☐	☐	☐	☐
☐ Obstructive Sleep Apnea	☐	☐	☐	☐	☐
☐ Sarcoidosis ☐ Asbestosis	☐	☐	☐	☐	☐
☐ Pulmonary Fibrosis ☐ Chronic Respiratory Failure	☐	☐	☐	☐	☐
☐ Tracheostomy	☐	☐	☐	☐	☐
☐ Other Diagnosis (specify): ______	☐	☐	☐	☐	☐

Musculoskeletal: ☐ **Reviewed and No Active Disease**	**Meds**	**Monitor**	**Diet**	**Labs**	**Referral**
☐ *Rheumatoid Arthritis; Last DMARD Rx fill date ______ ☐ Psoriatic Arthritis If **no DMARD** document rationale ______ Name of rheu arthritis med ______	☐	☐	☐	☐	☐
☐ Systemic Lupus Erythematous	☐	☐	☐	☐	☐
☐ Osteoarthritis Location(s): ______ Side: ☐ Right ☐ Left	☐	☐	☐	☐	☐
☐ Osteopenia Location(s): ______ Side: ☐ Right ☐ Left	☐	☐	☐	☐	☐
☐ Osteoporosis Location(s): ______ Side: ☐ Right ☐ Left Type: ☐ Senile ☐ Postmenopausal ☐ Unspecified Has the patient had a fracture in the past 12 months? ☐ Yes ☐ No If a fracture occurred, note specific bone location: ______ ☐ Right ☐ Left *Last Bone Density: ______ Bisphosphonate medication ☐ Yes ☐ No Denosumab ☐ Yes ☐ No Start Date of Osteoporosis medication: ______	☐	☐	☐	☐	☐
☐ S/P Amputation Location: ______ ☐ Right ☐ Left	☐	☐	☐	☐	☐
☐ Other Diagnosis (specify): ______	☐	☐	☐	☐	☐

Skin/Subcutaneous: ☐ **Reviewed and No Active Disease**	**Meds**	**Monitor**	**Diet**	**Labs**	**Referral**
☐ Pressure Ulcer: ☐ Stg1 ☐ Stg 2 ☐ Stg 3 ☐ Stg 4 ☐ Unstageable	☐	☐	☐	☐	☐
☐ Non Pressure Ulcer: ☐ Location (specify): ______ ☐ Right ☐ Left ☐ Both	☐	☐	☐	☐	☐
☐ Other Diagnosis (specify): ______	☐	☐	☐	☐	☐

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Member Name: DOB: / / DOS: / /

Renal/Urinary: ☐ **Reviewed and No Active Disease**	**Meds**	**Monitor**	**Diet**	**Labs**	**Referral**
*Urine Microalbumin Result: ________ Date: ________ eGFR: ________ (Provided GFRs need to be consistent for more than a 3 month period)					
☐ Chronic Kidney Disease (CKD) ☐ Stage 1 (GFR>90) ☐ Stage 2 (GFR 60-89) ☐ Proteinuria *(note: CKD 1 & 2 must have abnormal structural test, i.e. micro-albumin)*	☐	☐	☐	☐	☐
☐ CKD unspecified ☐ Stage 3 (GFR 30-59) ☐ Stage 4 (GFR 15-29) ☐ Stage 5 (GFR< 15)	☐	☐	☐	☐	☐
☐ ESRD Dialysis: ☐ Yes ☐ No	☐	☐	☐	☐	☐
☐ AV Fistula: ☐ Graft ☐ Catheter	☐	☐	☐	☐	☐
☐ Urinary Incontinence (check one): ☐ Unspecified ☐ Stress ☐ Urge	☐	☐	☐	☐	☐
☐ BPH ☐ w/ LUTS (specify): ________ ☐ w/o LUTS	☐	☐	☐	☐	☐
☐ Cystostomy	☐	☐	☐	☐	☐
☐ Secondary hyperparathyroidism of renal origin	☐	☐	☐	☐	☐
☐ Erectile dysfunction	☐	☐	☐	☐	☐
☐ Other Diagnosis (specify): ________	☐	☐	☐	☐	☐

Gastrointestinal: ☐ **Reviewed and No Active Disease**	**Meds**	**Monitor**	**Diet**	**Labs**	**Referral**
☐ Pancreatitis (chronic):	☐	☐	☐	☐	☐
☐ Cirrhosis liver: ☐ Alcoholic ☐ Non-Alcoholic	☐	☐	☐	☐	☐
☐ End stage liver disease	☐	☐	☐	☐	☐
☐ Colostomy ☐ Ileostomy	☐	☐	☐	☐	☐
☐ GERD	☐	☐	☐	☐	☐
☐ Crohn's Disease location(s): ________	☐	☐	☐	☐	☐
☐ Ulcerative Colitis, if complications exist specify ________	☐	☐	☐	☐	☐
☐ IBS ☐ w/ Diarrhea ☐ w/o Diarrhea	☐	☐	☐	☐	☐
☐ J Tube ☐ G Tube	☐	☐	☐	☐	☐
☐ Chronic Hepatitis - specify type: ________	☐	☐	☐	☐	☐
☐ Other Diagnosis (specify): ________	☐	☐	☐	☐	☐

Eye: ☐ **Reviewed and No Active Disease**	**Meds**	**Monitor**	**Diet**	**Labs**	**Referral**
☐ Cataract ☐ Senile Side: ☐ Right ☐ Left	☐	☐	☐	☐	☐
☐ Glaucoma Side: ☐ Right ☐ Left	☐	☐	☐	☐	☐
☐ Macular Degeneration ☐ Exudative ☐ Nonexudative ☐ Right ☐ Left	☐	☐	☐	☐	☐
☐ Legal Blindness ☐ Right ☐ Left ☐ Other Diagnosis (specify): ________	☐	☐	☐	☐	☐

Active Neoplasm/Blood Disorders and Current Treatment: ☐ **Reviewed and No Active Disease**	**Meds**	**Monitor**	**Diet**	**Labs**	**Referral**
☐ **Colon Cancer** ☐ Colectomy Date: ________ ☐ Chemo ☐ Radiation	☐	☐	☐	☐	☐
Metastatic and if so, to what site(s)? ________	☐	☐	☐	☐	☐
☐ **Breast Cancer** Neoplasm breast site ☐ Right ☐ Left Date: ________ Treatment: ☐ Mastectomy: ☐ Bilateral ☐ Unilateral Date: ________ ☐ Chemo ☐ Radiation ☐ Hormonal therapy	☐	☐	☐	☐	☐
☐ If Ductal Carcinoma in situ ☐ Right ☐ Left	☐	☐	☐	☐	☐
Metastatic and if so, to what site(s)? ________	☐	☐	☐	☐	☐
☐ **Prostate Cancer** ☐ Prostatectomy ☐ Treatment: ________	☐	☐	☐	☐	☐
Metastatic and if so, to what site(s)? ________	☐	☐	☐	☐	☐
☐ **Lung Cancer** ☐ R ☐ L ☐ Upper Lobe ☐ Lower Lobe ☐ Other: ________	☐	☐	☐	☐	☐
Treatment: ☐ Lobectomy ☐ Pneumonectomy ☐ Chemo ☐ Radiation	☐	☐	☐	☐	☐
Metastatic and if so, to what site(s)? ________	☐	☐	☐	☐	☐
☐ **Skin Cancer (type and site):** ________	☐	☐	☐	☐	☐
☐ Melanoma in Situ (site): ________	☐	☐	☐	☐	☐
☐ Other Malignancies (specify): ________	☐	☐	☐	☐	☐

Active Neoplasm/Blood Disorders and Current Treatment: ***Continued on Next Page***

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Member Name: **DOB:** / / **DOS:** / /

Active Neoplasm/Blood Disorders and Current Treatment (*Continued*)	**Meds**	**Monitor**	**Diet**	**Labs**	**Referral**
Myelodysplastic Disease					
Multiple Myeloma — Current — In Remission — Relapse					
Drug-induced Neutropenia (specify drug): ____________					
Anemia: Due to CKD — Drug - induced (specify drug):					
Due to Chemotherapy — B-12 — Iron — General					
Sickle Cell — Other: ____________					
HIV+ — AIDS					
Other Diagnosis (specify): ____________					
Neurological: **Reviewed and No Active Disease**	**Meds**	**Monitor**	**Diet**	**Labs**	**Referral**
CVA w/ Sequlae: *(note: specify below)*					
Specify late effect: Cognitive (specify): — Speech/Language — Aphasia					
Dysphagia — Other:					
Monoplegia — Dominant — Non-dominant — Left — Right — Upper Limb — Lower Limb					
Hemiplegia/Hemiparesis — Dominant — Non-dominant — Left — Right					
Weakness — Dominant — Non-dominant — Left — Right					
History of Trauma					
Hemiplegia/Hemiparesis — Dominant — Non-dominant — Left — Right					
Monoplegia — Dominant — Non-dominant — Left — Right — Upper Limb — Lower Limb					
Quadriplegia					
Multiple Sclerosis					
Myasthenia gravis					
ALS					
Polyneuropathy other than due to diabetes, specify ____________					
Parkinson's Disease: w/ Dementia — w/ Behavioral Disturbances					
Seizures — Seizure Disorder (Epilepsy)					
Other Diagnosis (specify):					
Psychiatric: **Reviewed and No Active Disease**	**Meds**	**Monitor**	**Diet**	**Labs**	**Referral**
Dementia: Unspecified — Vascular					
Senile — w/ Delusions — w/ Depression					
Alzheimer's disease: Early Onset — Late Onset					
w/ Dementia — w/ Dementia and Behavioral Disturbance					
Depressive Disorder — Mild — Major — If Major: Mild — Moderate — Severe					
If Major: Single Episode — Recurrent ▶ Full Remission — Partial Remission					
If Severe: w/ Psychotic Symptoms (consider psych referral if s/sx presents, recurrent, or suicidal) — w/o Psychotic Symptoms					
Anxiety					
Bipolar — Current — In Remission (Full — Partial)					
w/ Psychotic features — w/o Psychotic features					
Current type: Depressed — Manic — Mixed					
Current severity: Mild — Moderate — Severe					
Schizophrenia — Paranoid — Simple — Undifferentiated					
Disorganized — Other (specify): ____________					
Alcohol Use — Alcohol Abuse — Alcohol Dependence — In Remission					
Substance Use — Sbst. Abuse — Dependence — In Remission **Specify:** ____________					
Tobacco dependence					
Other Diagnosis (specify): ____________					

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Member Name: DOB: / / DOS: / /

Preventive Medicine: (Please Use "D" if patient declines, N/A, "S" for scheduled, or "A" for advised)

*Osteoporosis Screening (67-85) y/o): Date: ______ *Mammogram (52-74 y/o, every 27 mo.): Date ______

*Advanced care planning: Date ______ RESULT: ☐ Discussion held ☐ Medical Power Of Attorney ☐ Living Will ☐ Advanced Directive ☐ Organ Donor

*Colorectal Cancer Screening FOBT (Annual test b/t 50-75 yo), Date: ______ Sigmoidoscopy (Every 5 yrs), Date: ______

Colonoscopy (Every 10 yrs), Date: ______ Stool DNA [Cologuard] (Every 3 yrs), Date: ______ CT Colonography (Every 5 yrs), Date: ______

*Influenza Vaccine (65+y/o): Date: ______ ☐ Immunization(s) not carried out due to: ______

Pneumococcal Vaccine (65+y/o) Date Given: ______ ☐ Shingles Vaccine: Date: ______ Prevnar (65+y/o) Date Given: ______ (guidelines recommend giving each pneumococcal vaccine one year apart)

Long Term Medication Monitoring (Annual) ☐ Reviewed

Anticonvulsants (Phenobarbital, Carbamazepine, Phenytoin, Valproic acid): ______

Serum Drug Concentration: ______ Date: ______

Patients diagnosed with COPD:

Spirometry: ______ Date: ______

Beta Agonist/Anticholinergic Prescribed: ☐ Yes ☐ No

***Patients diagnosed with Diabetes:**

Is the patient on a statin? ☐ Yes ☐ No

*HbA1C: Date ______ Result: ______

*Microalbuminuria: Date ______ Result: ______

*Retinal Eye Exam: Date ______ Result: ☐ Normal ☐ Abnormal

*Name of Eye Care Provider: ______

Opioid Evaluation:

Has your patient required/used more than a 15 day supply of narcotic medication over the last 12 months for a non-terminal diagnosis? ☐ Yes ☐ No

If Yes, are there alternative options besides opioids for the patient's pain? ☐ Yes ☐ No

Patients diagnosed with CHF and/or CAD:

ACE or ARB Prescribed: ☐ Yes ☐ No

Beta Blocker Prescribed: ☐ Yes ☐ No

Statin Prescribed: ☐ Yes ☐ No

LVEF Assessment Date: ______ Result: ______

Please list any diagnoses, not already noted under current conditions, which affect patient care, treatment or management.

DIAGNOSES	SELECT TREATMENT PLAN						
	Meds	Monitor	Diet	Labs	Referral	Other	Describe
	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	
	☐	☐	☐	☐	☐	☐	

PLAN: ______

COORDINATION OF CARE (Please list any providers/specialists involved in the patient's care and any supplier of equipment): ☐ None

HMR reviewed and updated on today's visit? ☐ Yes ☐ No

BEHAVIORAL HEALTH REFERRAL: ☐ Yes ☐ No Indication: ______

CASE MANAGEMENT REFERRAL: ☐ Yes ☐ No ______

☐ Care Coordination ☐ Social Concerns ☐ Patient Education ☐ Other (specify): ______

If Yes, please specify: ______

I discussed the following with my patient:

☐ Tobacco cessation and education ☐ *Fall risk prevention ☐ Diet Modification ☐ High Risk Medications ☐ 90 Day Rx Fill

☐ *Urinary incontinence ☐ *Physical Activity ☐ Other (specify): ______

OTHER COMMENTS: ______

Patient Email (OPTIONAL)

RENDERING NAME: ______

RENDERING NPI:

☐ MD ☐ DO ☐ NP ☐ PA

RENDERING SIGNATURE: ______

DATE: ______

SUPERVISING PHYSICIAN NAME: ______
(if applicable)

☐ MD ☐ DO

SUPERVISING PHYSICIAN SIGNATURE: ______
(if applicable)

DATE: ______

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