Patient Name: **Gender:** **Date of Service:**
DOB: **Age:** **Race/Ethnicity:**

ANNUAL WELLNESS VISIT 2019 (FFS)

Vital signs: BP: _____ **P:**_____ **T:** _____ **R:**_____ **Ht:** _____ **Wt:** _____ **BMI:** _____ **Pulse Ox:** _____

Reason for Appointment: ☐ Initial Annual Wellness Visit ☐ Subsequent Annual Wellness Visit

Medical History: Does patient have/have history of any of the following *(check all that apply)*

Conditions		Conditions		Conditions	
Circulatory System		☐ Diabetic Cataract	**(E11.36)**	**Oncology/Hematology**	**(C-code)**
☐ AAA> 3cm	**(I71.4)**	☐ Diabetic Macular Edema	**(E11.311)**	☐ Cancer; type:	
☐ Aortic Tortuosity/Stricture/Ectasia	**(I77.819)**	☐ Diabetic Retinopathy	**(E11.319)**	Adjuvant therapy: Y / N	
☐ Atherosclerosis of Extremities; specify location and type: _____	**(I70.2x)**	☐ Proliferative Diabetic Retinopathy	**(E11.359)**	Is patient opting out of treatment: Y / N	
☐ Atherosclerotic Hrt Dis of Native Coronary Artery or CABG w/Angina	**(I25.119)**	☐ Diabetic PVD	**(E11.51)**	Mets: Y / N; specify:	
☐ Atherosclerosis of Aorta	**(I70.0)**	☐ Diabetic Gangrene	**(E11.5)**	**Ophthalmology**	
☐ Atherosclerosis of Renal Artery	**(I70.1)**	☐ **Diabetes w/other complications**	**(E11.69)**	☐ Glaucoma; type: _____	**(H40.1x)**
☐ Peripheral Vascular Disease	**(I73.9)**	☐ Diabetic Atherosclerosis	**(I70.2x)**	**Pulmonary**	
☐ Phlebitis and Thrombophlebitis of deep vessels of lower extremity	**(I80.209)**	☐ Diabetic CAD	**(I25.10)**	☐ Asthma; severity: _____	**(J45.x)**
☐ Varicose Veins with ulceration; location: _____	**(I83.0x)**	☐ Diabetic CABG	**(Z95.1)**	☐ Chronic Bronchitis	**(J42)**
☐ Angina Pectoris; (even if controlled by meds)	**(I20.9)**	☐ Diabetic s/p PTCA	**(Z98.61)**	☐ Chronic Respiratory Failure (O_2Sat<88%)	**(J96.10)**
☐ Atrial Fibrillation	**(I48.91)**	☐ Diabetic Erectile Dysfunction	**(N52.9)**	☐ COPD/Chronic Obstructive Asthma	**(J44.9)**
☐ Atrial Flutter	**(I48.92)**	☐ Diabetic Hyperlipidemia	**(E78.5)**	☐ Emphysema	**(J43.9)**
☐ PSVT	**(I47.1)**	☐ Diabetic Onychomycosis	**(B35.1)**	**Psychiatry**	
☐ Sick Sinus Syndrome/SA Node Dysfunction	**(I49.5)**	☐ Diabetic Ulcer Location & Stage:	**(L89.x)**	☐ Alcohol Dependence/Intoxication (even in remission)	**(F10.20)**
☐ Heart Failure; specify: _____	**(I50.x)**	☐ Hyper- or Hypo- Parathyroidism	**(E2x.x)**	☐ Substance Use Disorder (not valid if pt on pain management or under MD supervision)	**(F11.x-F19.x)**
☐ Hyperlipidemia	**(E78.5)**	☐ Malnutrition; specify:	**(E4x)**	☐ Bipolar Disorder	**(F31.9)**
☐ Hypertension: Essential (Primary)	**(I10)**	☐ Morbid Obesity (BMI>40)	**(E66.01)**	☐ Major Depression; Single Episode severity: _____	**(F32.x)**
☐ Hypertensive Heart Disease with Heart Failure	**(I11.0)**	☐ BMI 40.0-44.9	**(Z68.41)**	☐ Major Depression; Recurrent Episode severity: _____	**(F33.x)**
☐ Hypertensive Heart Disease without Heart Failure	**(I11.9)**	☐ BMI 45.0-49.9	**(Z68.42)**	☐ Schizophrenia	**(F20.9)**
☐ Hypertensive CKD Stage 1-4	**(I12.9)**	☐ BMI 50.0-59.9	**(Z68.43)**	**Rheumatology**	
☐ Hypertensive CKD Stage 5 or ESRD	**(I12.0)**	☐ BMI 60.0-69.9	**(Z68.44)**	☐ Osteoporosis	**(M81.0)**
☐ Hypertensive Heart Disease and CKD Stage 1-4 with Heart Failure	**(I13.0)**	☐ BMI 70.0 & over	**(Z68.45)**	☐ Pathologic Vertebral Fx	**(M48.57XA)**
☐ Hypertensive Heart Disease and CKD Stage 1-4 without Heart Failure	**(I13.10)**	☐ Obesity hypoventilation syndrome	**(E66.2)**	☐ Rheumatoid Arthritis	**(M06.9)**
☐ Hypertensive Heart Disease and CKD Stage 5 or ESRD without Heart Failure	**(I13.11)**	**Gastroenterology**		**Skin & Subcutaneous Tissue**	
☐ Hypertensive Heart Disease and CKD Stage 5 or ESRD with Heart Failure	**(I13.2)**	☐ Alcoholic Liver Disease	**(K70.9)**	☐ Non-Pressure Ulcer: Y / N Location:	**(L97.x)**
☐ Old MI (>8 weeks)	**(I25.2)**	☐ Chronic Hepatitis	**(K73.9)**	☐ Pressure Ulcer: Y / N Location/Stage:	**(L89.x)**
☐ Primary Pulmonary Hypertension	**(I27.0)**	☐ Chronic Viral Hepatitis	**(B18.9)**	**Status**	
☐ Secondary Hypertension	**(I15.9)**	☐ Cirrhosis	**(K74.60)**	☐ Amputation; site: ____	**(Z89.x)**
Endocrinology/Metabolic		☐ Fecal Impaction	**(K56.41)**	☐ Ostomy; type: _____	**(Z93.x)**
☐ Long term Insulin use	**(Z79.4)**	☐ Crohn's Disease	**(K50.90)**	☐ Transplant; type: _____	**(Z94.x)**
☐ Diabetes Mellitus w/o complications	**(E11.9)**	☐ Ulcerative Colitis	**(K51.90)**	**Other**	
☐ Diabetic Nephropathy	**(E11.21)**	**Genitourinary System**		1.	
☐ Diabetic CKD	**(E11.22)**	☐ CKD 4	**(N18.4)**	2.	
☐ CKD stage 4	**(N18.4)**	☐ CKD 5	**(N18.5)**	3.	
☐ CKD stage 5	**(N18.5)**	☐ Dialysis Non-Compliance	**(Z91.15)**	4.	
☐ Diabetic Neuropathy	**(E11.42)**	☐ ESRD	**(N18.6)**	5.	
☐ Diabetic Gastroparesis	**(E11.43)**	☐ Peritoneal Dialysis	**(Z49.01)**		
		☐ Renal Dialysis	**(Z99.2)**		
		Neurology			
		☐ Alzheimer's Disease	**(G30.x)**		
		☐ Migraines; type: _____	**(G43.x)**		
		☐ Old CVA; late effects: _____	**(I69.x)**		
		☐ Parkinson's Disease	**(G20)**		
		☐ Seizure or Epilepsy	**(G40.x)**		

Provider Signature: _____ **Date:** _____
Print Name & Credentials: _____

Patient Name: **Gender:** **Date of Service:**
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Family History:

	Relationship: (circle)
☐ Alcohol Dependence/Intoxication	Mother/Father/Sister/Brother/other:
☐ Asthma/COPD	Mother/Father/Sister/Brother/other:
☐ Cancer; type: _____	Mother/Father/Sister/Brother/other:
☐ Coronary Artery Disease	Mother/Father/Sister/Brother/other:
☐ Major Depression/Suicide	Mother/Father/Sister/Brother/other:
☐ Diabetes Mellitus; type:	Mother/Father/Sister/Brother/other:
☐ Glaucoma	Mother/Father/Sister/Brother/other:
☐ Hyperlipidemia	Mother/Father/Sister/Brother/other:
☐ Hypertension	Mother/Father/Sister/Brother/other:
☐ Stroke	Mother/Father/Sister/Brother/other:
☐ Other:	Mother/Father/Sister/Brother/other:

Surgical/Hospital History:

List of current Providers/Suppliers (Pharmacy) regularly involved in member's medical care:

_____

Allergies:

Current Medications: (please list all known prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements AND dosages, frequency and route of administration)

☐ No current medications
☐ Please see attached medication list

☐ Provider reviewed and reconciled medication list
☐ Provider reviewed and reconciled medication list post-discharge (30 days)
Date of discharge(s): _____

_____
_____
_____
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_____
_____

☐ No new treatment options required
☐ Risks & Benefits for new treatment option(s) discussed with patient. Please list treatment options (i.e. new medications prescribed, dialysis treatment, etc.) below.
☐ Treatment options offered and patient declined

Treatment Options
1.
2.
3.
4.
5.

Provider Signature: _____ Date: _____
Print Name & Credentials: _____

Patient Name: **Gender:** **Date of Service:**
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Please check any that applies ☐HMO ☐Hospice ☐ESRD ☐Permanent NH ☐Expired Date:

ACO QUALITY MEASURE CHECKLIST

Measure Name	Last DOS	Documented ✓	CPT/ICD-10 Codes
Medication Reconciliation Post-Discharge (30 days) **Falls:** Screening for Future Fall Risk (2019)		☐ Document date of discharge(s) & provider reconciled current & discharge medications for each discharge ☐ Pt screened or assessed for history of 2 or more falls or any fall with injury ☐ 0-1 falls	**1111F** **1101F** (0-1 falls) **1100F** (2+ falls or any fall with injury)
HbA1c Poor Control >9.0% (2019) *(Adults 18-75)*		☐ Diabetes diagnosis; *and* ☐ Most recent HbA1c result:	**ICD-10 (Diabetes): Ell.___** **3046F** (most recent HbA1c >9.0%)
Retinal or Dilated Eye Exam in 2018 or negative retinal exam (no retinopathy) in 2017 by an ophthalmologist or optometrist *(Adults 18-75)*		☐ Diabetes diagnosis; *and* ☐ Report attached; *and* ☐ **Negative** Retinal/Dilated Eye Exam (no retinopathy) in 2017; *or* ☐ Retinal/Dilated Eye Exam for 2018 results show:	**ICD-10 (Diabetes): Ell.___** **2022F** (dilated retinal eye exam) **2024F** (seven standard field stereoscopic photos) **2026F** (eye imaging validated to match diagnosis from seven standard field stereoscopic photos) **3072F** (Low risk for retinopathy, no evidence of retinopathy in prior year)
Diagnosed with AMI/CABG/PCI in 2018 or active diagnosis of IVD with documentation of use of **Aspirin or another antiplatelet medication**		☐ Active diagnosis of IVD; *or* ☐ AMI/CABG/PCI diagnosis in 2017; *and* **Active prescription** (Check Category) ☐ Aspirin/Aggrenox/Plavix/Prasugrel ☐ Eliquis/Heparin/Lovenox/Pradaxa/Xarelto, or Warfarin	**G8598** (Aspirin or another antiplatelet therapy used)
Controlled BP <140/90 mmHg HTN diagnosis w/in first 6 months of 2019 or prior but does not end before 1/1/19 *(Adults 18-85)*		☐ HTN diagnosis; *and* ☐ Most recent BP reading:	**ICD-10 (HTN): I10** **G8752** (Systolic BP < 140mmHg) **G8754** (Diastolic BP < 90mmHg)
Major Depression/Dysthymia Remission (PHQ-9 < 5) at 12 mo.		☐ Major Depressive Disorder diagnosis; *or* ☐ Dysthymia Disorder diagnosis; *and* ☐ PHQ-9 >9 (12/1/16-11/30/17); *and* ☐ f/u PHQ-9 <5 at 12 months	**ICD-10 (MDD): F33.____** **ICD-10 (Dysthymia): F34.1____** **G9509** (remission at 12 months)
Breast Cancer Screen (on or between 10/1/17-12/31/19) *(Women 50-74)*		☐ Report attached; *and* ☐ Normal ☐ Abnormal	**3014F** (results documented & reviewed)
Colorectal Cancer Screen (2019 or indicated timeframe) Fecal occult blood; *or* Flexible Sigmoidoscopy (4 yrs prior 1/1/19); *or* Colonoscopy (9 years prior 1/1/19); *or* CT colonography (4 yrs prior 1/1/19); *or* Fecal immunochemical DNA test (FIT-DNA) (2 yrs prior 1/1/19) *(Adults 50-75)*		☐ Report attached; *and* ☐ Normal ☐ Abnormal ☐ Normal ☐ Abnormal ☐ Normal ☐ Abnormal ☐ Normal ☐ Abnormal ☐ Normal ☐ Abnormal	**3017F** (screening results documented and reviewed)
Vaccinations Pneumococcal (once in a lifetime) Influenza (8/1/18- 3/31/19)		☐Pneumococcal vaccine received; *and* ☐PPSV23 *or* ☐PCV13 (if given between 2015-2018) ☐Influenza vaccine received	**4040F** (Pneumococcal vaccine administered or previously received) **G8482** (Influenza vaccine administered or previously received)
BMI Screening and Follow-Up Plan if abnormal (most recent visit in 2019 or previous 6 months) (Normal BMI= 18.5 kg/m2 - 25 kg/m2)		☐ Most recent BMI result: ☐ Follow-up plan given: education/referral/medication/exercise & nutrition counseling/dietary supplements	**G8420** (BMI normal, no f/u) **G8417** (BMI above normal & f/u required) **G8418** (BMI below normal & f/u required)
Tobacco Use: Screened at least once within 24 months and cessation intervention (within 24 months of screened date) if positive tobacco user		☐ Tobacco user ☐ Tobacco cessation intervention given ☐ Tobacco non-user	**4004F** (screened for tobacco use & received cessation intervention) **1036F** (current tobacco non-user)
Clinical Depression Screening and Follow-Up Plan if positive (2019)		☐ PHQ-9 result: ☐ Follow-Up Plan: additional eval given for depression/suicide risk assessment/referral/medication/other intervention	**G8431** (positive screening & f/u plan documented) **G8510** (negative screening documented, f/u plan not required)
Cardiovascular Disease: *(Adults 21+)* Previous or current diagnosis of ASCVD/Familial or Pure Hypercholesterolemia; *or* Fasting or direct LDL-C >= 190 mg/dL; *or* Diabetes with fasting or direct LDL-C of 70-189 mg/dL (Adults 40-75) **who was prescribed Statin Therapy**		☐ ASCVD/Familial or Pure Hypercholesterolemia diagnosis; *or* ☐ LDL-C result: ☐ *or* DM diagnosis *and* LDL-C result: ☐ *and* Statin Therapy Rx	**G9664** (current statin therapy users or received a prescription for statin therapy)

Provider Signature: _____ **Date:** _____
Print Name & Credentials: _____

Patient Name: **Gender:** **Date of Service:**
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Health Risk Assessment/Individualized Care Plan

(Please keep on file and provide member with a copy)

WELL BEING:

1. Considering your age, how would you describe your overall physical health? ☐Excellent ☐Good ☐Fair ☐Poor

2. In general, how satisfied are you with your life? ☐ Mostly satisfied ☐ Partly satisfied ☐ Not satisfied

3. Do you have a history of depression or mood disorders? ☐Yes or ☐ No

BEHAVIORAL:

1. Do you use tobacco? ☐ Tobacco non-user ☐ Tobacco user
# of packs per year _____ Year Quit _____

2. Do you drink alcohol? ☐Yes or ☐ No # of drinks per week _____

3. Do you use recreational drugs? ☐Yes or ☐ No Specify:_____

4. How many times a week do you engage in physical activity? ☐0 ☐ 1-3 ☐ 4-5 ☐ 6 or more

5. Describe your nutrition/diet:

ACTIVITY OF DAILY LIVING:

1. Do you have any difficulty doing any of the following activities by yourself? ☐ Yes ☐ No
☐Dressing ☐Prepare food ☐Feeding ☐Bathing ☐Using the toilet ☐ Grooming ☐ Walking ☐Getting to and from bed or chair ☐Shopping ☐Using a phone ☐Housekeeping (laundry) ☐Paying bills ☐Taking medications
☐Using transportation - Specify mode:

FUNCTIONAL ASSESSMENT/RISK:

1. Do you have difficulty with your hearing? ☐Yes or ☐No

2. Do you have difficulty with your vision/eyesight? ☐Yes or ☐No

3. Do you feel safe at home? ☐Yes or ☐No

4 How many times have you fallen in the past 12 months? ☐ 0 ☐1-2 ☐3-4 ☐ 5 or more Any major injuries? ☐Yes or ☐No

5. Do you have an advance directive or POLST? ☐Yes or ☐No If Yes, Date:
If No, discussed with member? ☐Yes or ☐No

Provider Signature: _____ Date: _____
Print Name & Credentials: _____

Patient Name: **Gender:** **Date of Service:**
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Diagnosis/Risk Factors (including mental conditions)	Plan: M.E.A.T **M**onitor: continue to monitor, continue to follow w/specialist **E**valuate: order labs, evals, tests **A**ssess: new, stable, improved, worsening, resolved Treat: start/continue (name of meds), order PT/OT, perform procedure or educate/counsel
	M: **E:** **A:** **T:**
	M: **E:** **A:** **T:**
	M: **E:** **A:** **T:**
	M: **E:** **A:** **T:**
	M: **E:** **A:** **T:**

Provider Signature: _____ **Date:** _____
Print Name & Credentials: _____

Patient Name: **Gender:** **Date of Service:**
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Cognitive Assessment

Mini-Cog Test *(Check the boxes that are applicable)*

1. Ask your member to remember three unrelated words. (Ball, Car, Penny) Then ask the member to recall the three words about 5 minutes later.
2. How many words can the member recall?
   - ☐ 0 (Abnormal Mini-Cog Test Result. No need to do #3 and #4
   - ☐ 1-2 (Continue on #3)
   - ☐ 3 (Normal Mini-Cog Test Result. No need to do #3 and #4)
3. If the member was able to recall all three objects. There is no need to draw clock. If not, ask your member to draw "forty five minutes past ten o'clock".in the space below.
4. Is the clock drawing normal? ☐ Yes (Normal Mini-Cog Test Result)
   ☐ No (Abnormal Mini-Cog Test Result)

DEPRESSION SCREENING

(PHQ-9) Risk for Depression Screening: *Please complete the following questionnaire.*

Over the last two weeks, how often have you been bothered by any of the following problems? ***(Use "X" 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

Add columns:
TOTAL: _____

Diagnosis (Must Check One)
- ☐ (0-4) No Depression
- ☐ (5-9) Mild Depression
- ☐ (10-14) Moderate Depression
- ☐ (15-19) Moderately Severe Depression
- ☐ (20-27) Severe Depression

Plan (Must Check All that Apply)
- ☐ No treatment required/Observation
- ☐ Prescribe medications
- ☐ Consultations
- ☐ Specialist Referral
- ☐ Others; specify _____

Provider Signature: _____ Date: _____
Print Name & Credentials: _____