

Patient Name  
 DOB:  
 Next Due Date:

Gender:  
 Age:

Date of Service:  
 Race/Ethnicity:



ANNUAL WELLNESS VISIT 2023 (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
<b>Circulatory System</b>	<input type="checkbox"/> CKD stage 4 (N18.4)	<b>Oncology/Hematology (C-code)</b>
<input type="checkbox"/> AAA> 3cm (I71.4)	<input type="checkbox"/> CKD stage 5 (N18.5)	<input type="checkbox"/> Cancer; type: _____
<input type="checkbox"/> Aortic Tortuosity/Stricture/Ectasia (I77.819)	<input type="checkbox"/> Diabetic Neuropathy (E11.42)	Adjuvant therapy: Y / N
<input type="checkbox"/> Atherosclerosis of Extremities; specify location and type: _____ (I70.2x)	<input type="checkbox"/> Diabetic Gastroparesis (E11.43)	Is patient opting out of treatment: Y / N
<input type="checkbox"/> Atherosclerotic Hrt Dis of Native Coronary Artery or CABG w/Angina (I25.119)	<input type="checkbox"/> Diabetic Cataract (E11.36)	Mets: Y / N; specify: _____
<input type="checkbox"/> Atherosclerosis of Aorta (I70.0)	<input type="checkbox"/> Diabetic Macular Edema (E11.311)	<b>Ophthalmology</b>
<input type="checkbox"/> Atherosclerosis of Renal Artery (I70.1)	<input type="checkbox"/> Diabetic Retinopathy (E11.319)	<input type="checkbox"/> Glaucoma; type: _____ (H40.1x)
<input type="checkbox"/> Peripheral Vascular Disease (I73.9)	<input type="checkbox"/> Proliferative Diabetic Retinopathy (E11.359)	<b>Pulmonary</b>
<input type="checkbox"/> Phlebitis and Thrombophlebitis of deep vessels of lower extremity (I80.209)	<input type="checkbox"/> Diabetic PVD (E11.51)	<input type="checkbox"/> Asthma; severity: _____ (J45.x)
<input type="checkbox"/> Varicose Veins with ulceration; location: _____ (I83.0x)	<input type="checkbox"/> Diabetic Gangrene (E11.5)	<input type="checkbox"/> Chronic Bronchitis (J42)
<input type="checkbox"/> Angina Pectoris; (even if controlled by meds) (I20.9)	<input type="checkbox"/> <b>Diabetes w/other complications</b> (E11.69)	<input type="checkbox"/> Chronic Respiratory Failure (O <sub>2</sub> Sat<88%) (J96.10)
<input type="checkbox"/> Atrial Fibrillation (I48.91)	<input type="checkbox"/> Diabetic Atherosclerosis (I70.2x)	<input type="checkbox"/> COPD/Chronic Obstructive Asthma (J44.9)
<input type="checkbox"/> Atrial Flutter (I48.92)	<input type="checkbox"/> Diabetic CAD (I25.10)	<input type="checkbox"/> Emphysema (J43.9)
<input type="checkbox"/> PSVT (I47.1)	<input type="checkbox"/> Diabetic CABG (Z95.1)	<b>Psychiatry</b>
<input type="checkbox"/> Sick Sinus Syndrome/SA Node Dysfunction (I49.5)	<input type="checkbox"/> Diabetic s/p PTCA (Z98.61)	<input type="checkbox"/> Alcohol Dependence/Intoxication (F10.20) (even in remission)
<input type="checkbox"/> Heart Failure; specify: _____ (I50.x)	<input type="checkbox"/> Diabetic Erectile Dysfunction (N52.9)	<input type="checkbox"/> Substance Use Disorder (F11.xx-F19.xx) (not valid if pt on pain management or under MD supervision)
<input type="checkbox"/> Hyperlipidemia (E78.5)	<input type="checkbox"/> Diabetic Hyperlipidemia (E78.5)	<input type="checkbox"/> Opioid abuse, uncomplicated (F11.10)
<input type="checkbox"/> Hypertension: Essential (Primary) (I10)	<input type="checkbox"/> Diabetic Onychomycosis (B35.1)	<input type="checkbox"/> Opioid dependence, uncomplicated (F11.20)
<input type="checkbox"/> Hypertensive Heart Disease with Heart Failure (I11.0)	<input type="checkbox"/> Diabetic Ulcer (L89.x)	<input type="checkbox"/> Other psychoactive substance abuse, uncomplicated (F19.10)
<input type="checkbox"/> Hypertensive Heart Disease without Heart Failure (I11.9)	Location & Stage:	<input type="checkbox"/> Bipolar Disorder (F31.9)
<input type="checkbox"/> Hypertensive CKD Stage 1-4 (I12.9)	<input type="checkbox"/> Hyper- or Hypo- Parathyroidism (E2x.x)	<input type="checkbox"/> Major Depression; Single Episode severity: _____ (F32.x)
<input type="checkbox"/> Hypertensive CKD Stage 5 or ESRD (I12.0)	<input type="checkbox"/> Malnutrition; specify: _____ (E4x)	<input type="checkbox"/> Major Depression; Recurrent Episode severity: _____ (F33.x)
<input type="checkbox"/> Hypertensive Heart Disease and CKD Stage 1-4 with Heart Failure (I13.0)	<input type="checkbox"/> Morbid Obesity (BMI>40) (E66.01)	<input type="checkbox"/> Schizophrenia (F20.9)
<input type="checkbox"/> Hypertensive Heart Disease and CKD Stage 1-4 without Heart Failure (I13.10)	<input type="checkbox"/> BMI 40.0-44.9 (Z68.41)	<b>Rheumatology</b>
<input type="checkbox"/> Hypertensive Heart Disease and CKD Stage 5 or ESRD without Heart Failure (I13.11)	<input type="checkbox"/> BMI 45.0-49.9 (Z68.42)	<input type="checkbox"/> Osteoporosis (M81.0)
<input type="checkbox"/> Hypertensive Heart Disease and CKD Stage 5 or ESRD with Heart Failure (I13.2)	<input type="checkbox"/> BMI 50.0-59.9 (Z68.43)	<input type="checkbox"/> Pathologic Vertebral Fx (M48.57XA)
<input type="checkbox"/> Old MI (>8 weeks) (I25.2)	<input type="checkbox"/> BMI 60.0-69.9 (Z68.44)	<input type="checkbox"/> Rheumatoid Arthritis (M06.9)
<input type="checkbox"/> Primary Pulmonary Hypertension (I27.0)	<input type="checkbox"/> BMI 70.0 & over (Z68.45)	<b>Skin &amp; Subcutaneous Tissue</b>
<input type="checkbox"/> Secondary Hypertension (I15.9)	<input type="checkbox"/> Obesity hypoventilation syndrome (E66.2)	<input type="checkbox"/> Non-Pressure Ulcer: Y / N Location: _____ (L97.x)
<b>Endocrinology/Metabolic</b>	<b>Gastroenterology</b>	<input type="checkbox"/> Pressure Ulcer: Y / N Location/Stage: _____ (L89.x)
<input type="checkbox"/> Long term Insulin use (Z79.4)	<input type="checkbox"/> Alcoholic Liver Disease (K70.9)	<b>Status</b>
<input type="checkbox"/> Diabetes Mellitus w/o complications (E11.9)	<input type="checkbox"/> Chronic Hepatitis (K73.9)	<input type="checkbox"/> Amputation; site: _____ (Z89.xxx)
<input type="checkbox"/> Diabetic Nephropathy (E11.21)	<input type="checkbox"/> Chronic Viral Hepatitis (B18.9)	<input type="checkbox"/> Ostomy; type: _____ (Z93.x)
<input type="checkbox"/> Diabetic CKD (E11.22)	<input type="checkbox"/> Cirrhosis (K74.60)	<input type="checkbox"/> Transplant; type: _____ (Z94.x)
<input type="checkbox"/> CKD stage 3 (N18.3)	<input type="checkbox"/> Fecal Impaction (K56.41)	<b>Other</b>
<input type="checkbox"/> CKD stage 3A Moderate CKD (Unspecified) (N18.30)	<input type="checkbox"/> Crohn's Disease (K50.90)	1. _____
<input type="checkbox"/> CKD stage 3B Moderate CKD (GFR = 45-59 mL/min) (N18.31)	<input type="checkbox"/> Ulcerative Colitis (K51.90)	2. _____
<input type="checkbox"/> CKD stage 3B Moderate CKD (GFR = 30-44 mL/min) (N18.32)	<b>Genitourinary System</b>	3. _____
	<input type="checkbox"/> CKD 3 (N18.3)	4. _____
	<input type="checkbox"/> CKD 4 (N18.4)	5. _____
	<input type="checkbox"/> CKD 5 (N18.5)	
	<input type="checkbox"/> Dialysis Non-Compliance (Z91.15)	
	<input type="checkbox"/> ESRD (N18.6)	
	<input type="checkbox"/> Peritoneal Dialysis (Z49.01)	
	<input type="checkbox"/> Renal Dialysis (Z99.2)	
	<b>Neurology</b>	
	<input type="checkbox"/> Alzheimer's Disease (G30.x)	
	<input type="checkbox"/> Migraines; type: _____ (G43.x)	
	<input type="checkbox"/> Old CVA; late effects: _____ (I69.x)	
	<input type="checkbox"/> Parkinson's Disease (G20)	
	<input type="checkbox"/> Seizure or Epilepsy (G40.x)	

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
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**Family History:**

- Alcohol Dependence/Intoxication
- Asthma/COPD
- Cancer; type: \_\_\_\_\_
- Coronary Artery Disease
- Major Depression/Suicide
- Diabetes Mellitus; type: \_\_\_\_\_
- Glaucoma
- Hyperlipidemia
- Hypertension
- Stroke
- Other Hereditary Medical Events:

**Relationship: (circle)**

- Mother/Father/Sister/Brother/other:
- Mother/Father/Sister/Brother/other:
- Mother/Father/Sister/Brother/other:
- Mother/Father/Sister/Brother/other:
- Mother/Father/Sister/Brother/other:
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- Mother/Father/Sister/Brother/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

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- Opioid User Identified
- No new treatment options required
- Risks & Benefits for new treatment option(s) discussed with patient. Please list treatment options (i.e. new medications prescribed, non-opioid pain treatments, dialysis treatment, etc.) below.
- Treatment options offered and patient declined

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

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Please check any that applies HMO Hospice ESRD Permanent NH Expired Date:

### FCACO QUALITY MEASURE CHECKLIST

Measure Name	Last DOS Performed	Documented ✓	CPT/ICD-10 Codes
<b>Falls:</b> Screening for Future Fall Risk (2022) <i>(Adults 65+)</i>		Pt screened or assessed for history of falls: <input type="checkbox"/> 0-1 falls <input type="checkbox"/> 2 or more falls or <i>any</i> fall with injury	<b>1101F</b> (0-1 falls) <b>1100F</b> (2+ falls or any fall with injury)
<b>Diabetes Type 1 or 2: HbA1c Poor Control &gt;9.0%</b> (2021-2022) <i>(Adults 18-75)</i>		<input type="checkbox"/> Diabetes Type 1 or 2 diagnosis; <i>and</i> <input type="checkbox"/> Most recent HbA1c result is:	<b>ICD-10 (Diabetes): E11.____</b> <b>3046F</b> (most recent HbA1c >9.0%)
<b>Essential or Primary Hypertension: Controlled BP &lt;140/90 mmHg</b> HTN diagnosis w/in first 6 months of 2022 or before 2022, continuing into 2022. <i>(Adults 18-85)</i>		<input type="checkbox"/> Essential or Primary Hypertension diagnosis; <i>and</i> <input type="checkbox"/> Most recent BP reading is:	<b>ICD-10 (HTN): I10</b> <b>G8752</b> (Systolic BP < 140mmHg) <b>G8754</b> (Diastolic BP < 90mmHg)
<b>Major Depression/Dysthymia Remission</b> (PHQ-9 < 5) at 12 mo. <i>(Adults 18+ or 12-17 y.o)</i>		<input type="checkbox"/> Major Depressive Disorder diagnosis; <i>or</i> <input type="checkbox"/> Dysthymia Disorder diagnosis; <i>and</i> <input type="checkbox"/> PHQ-9 >9 (11/1/20-10/31/21); <i>and</i> <input type="checkbox"/> f/u PHQ-9 <5 at 12 months +/- 60 days	<b>ICD-10 (MDD): F33.____</b> <b>ICD-10 (Dysthymia): F34.1____</b> <b>G9509</b> (remission at 12 months)
<b>Breast Cancer Screen</b> (on or between 10/1/20-12/31/22) <i>(Women 50-74)</i>		<input type="checkbox"/> Report attached; <i>and</i> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<b>3014F</b> (results documented & reviewed)
<b>Colorectal Cancer Screen</b> (2022 or indicated timeframe) Fecal occult blood; <i>or</i> Flexible Sigmoidoscopy (2018-2022); <i>or</i> Colonoscopy (2013-2022); <i>or</i> CT colonography (2018-2022); <i>or</i> Fecal immunochemical DNA test (FIT-DNA) (2020-2022) <i>(Adults 50-75)</i>		<input type="checkbox"/> Report attached; <i>and</i> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	<b>3017F</b> (screening results documented and reviewed)
<b>Vaccinations</b> Influenza (8/1/22-3/31/23) <i>(6mo+)</i>		<input type="checkbox"/> Influenza vaccine received <input type="checkbox"/> Patient reported receipt of Influenza Immunization <input type="checkbox"/> Patient declined Influenza Immunization	<b>G8482</b> (Influenza vaccine administered or previously received)
<b>Tobacco Use:</b> Screened at least once during 2022 and received cessation intervention (within the previous 12 months) if positive tobacco user <i>(Adults 18+)</i>		<input type="checkbox"/> Tobacco user <input type="checkbox"/> Tobacco cessation intervention given <input type="checkbox"/> Tobacco non-user	<b>4004F</b> (screened for tobacco use & received cessation intervention) <b>1036F</b> (current tobacco non-user)
<b>Clinical Depression Screening and Follow-Up Plan</b> if positive (2021) <i>(12 y.o+)</i>		<input type="checkbox"/> Negative PHQ-9 <input type="checkbox"/> Positive PHQ-9 <input type="checkbox"/> Follow-Up Plan if positive: referral for additional evaluation given for depression/medication/other intervention <input type="checkbox"/> Patient refused Depression Screening	<b>G8431</b> (positive screening & f/u plan documented) <b>G8510</b> (negative screening documented, f/u plan not required)
<b>Cardiovascular Disease:</b> Previous or current diagnosis of ASCVD or ASCVD procedure Familial Hypercholesterolemia or fasting or direct LDL-C $\geq$ 190 mg/dL (Adults 20+); <i>or</i> Diabetes Type 1 or Type 2 (Adults 40-75)  <b>Who were prescribed or were on Statin Therapy in 2022</b>		<input type="checkbox"/> Atherosclerosis Cardiovascular Disease or procedure; <i>or</i> <input type="checkbox"/> Familial Hypercholesterolemia diagnosis; <i>or</i> <input type="checkbox"/> LDL-C result is: <input type="checkbox"/> <i>or</i> Diabetes Type 1 or Type 2 diagnosis (2022)  <input type="checkbox"/> <i>and</i> Statin Therapy Rx	<b>G9664</b> (current statin therapy users or received a prescription for statin therapy)

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
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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 user  Tobacco non-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: \_\_\_\_\_  
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### Plan: M.E.A.T

Diagnosis/Risk Factors  
(including mental conditions)

Monitor: continue to monitor, continue to follow w/specialist  
Evaluate: order labs, evals, tests  
Assess: new, stable, improved, worsening, resolved  
Treat: start/continue (name of meds), order PT/OT, perform procedure or educate/counsel

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Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
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Office Use Only				
Six Item Cognitive Impairment Test (6CI)				
1	Ask patient to remember three words <ul style="list-style-type: none"> <li>• Apple</li> <li>• Table</li> <li>• Penny</li> </ul>	Make sure patient can repeat three words properly and inform him/her that you will ask to repeat later.		Yes No
				<b>Score</b>
2	What year is this?	<input type="checkbox"/> Correct (0 pts.)	<input type="checkbox"/> Incorrect (3 pts.)	
3	What month is this?	<input type="checkbox"/> Correct (0 pts.)	<input type="checkbox"/> Incorrect (3 pts.)	
4	What is the day of the week?	<input type="checkbox"/> Correct (0 pts.)	<input type="checkbox"/> Incorrect (4 pts.)	
5	Repeat information from #1	<input type="checkbox"/> Correct (0 pts.)	<input type="checkbox"/> 1 error (3 pts.)	<input type="checkbox"/> 2 errors (4 pts.)
		<input type="checkbox"/> 3 errors (6 pts.)	<input type="checkbox"/> 4 errors (8 pts.)	<input type="checkbox"/> All incorrect (10 pts.)
<b>Add all scores for Total</b>				

## 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

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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 \_\_\_\_\_

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 Print Name & Credentials: \_\_\_\_\_