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

FAMILY CHOICE ACO
PHYSICIAN-LED ACCOUNTABLE CARE ORGANIZATION

ANNUAL WELLNESS VISIT 2024 (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

Circulatory System
- ☐ AAA> 3cm **(I71.4)**
- ☐ Aortic Tortuosity/Stricture/Ectasia **(I77.819)**
- ☐ Atherosclerosis of Extremities; specify location and type: _____ **(I70.2x)**
- ☐ Atherosclerotic Hrt Dis of Native Coronary Artery or CABG w/Angina **(I25.119)**
- ☐ Atherosclerosis of Aorta **(I70.0)**
- ☐ Atherosclerosis of Renal Artery **(I70.1)**
- ☐ Peripheral Vascular Disease **(I73.9)**
- ☐ Phlebitis and Thrombophlebitis of deep vessels of lower extremity **(I80.209)**
- ☐ Varicose Veins with ulceration; location: _____ **(I83.0x)**
- ☐ Angina Pectoris; (even if controlled by meds) **(I20.9)**
- ☐ Atrial Fibrillation **(I48.91)**
- ☐ Atrial Flutter **(I48.92)**
- ☐ PSVT **(I47.1)**
- ☐ Sick Sinus Syndrome/SA Node Dysfunction **(I49.5)**
- ☐ Heart Failure; specify: _____ **(I50.x)**
- ☐ Hyperlipidemia **(E78.5)**
- ☐ Hypertension: Essential (Primary) **(I10)**
- ☐ Hypertensive Heart Disease with Heart Failure **(I11.0)**
- ☐ Hypertensive Heart Disease without Heart Failure **(I11.9)**
- ☐ Hypertensive CKD Stage 1-4 **(I12.9)**
- ☐ Hypertensive CKD Stage 5 or ESRD **(I12.0)**
- ☐ Hypertensive Heart Disease and CKD Stage 1-4 with Heart Failure **(I13.0)**
- ☐ Hypertensive Heart Disease and CKD Stage 1-4 without Heart Failure **(I13.10)**
- ☐ Hypertensive Heart Disease and CKD Stage 5 or ESRD without Heart Failure **(I13.11)**
- ☐ Hypertensive Heart Disease and CKD Stage 5 or ESRD with Heart Failure **(I13.2)**
- ☐ Old MI (>8 weeks) **(I25.2)**
- ☐ Primary Pulmonary Hypertension **(I27.0)**
- ☐ Secondary Hypertension **(I15.9)**

Endocrinology/Metabolic
- ☐ Long term Insulin use **(Z79.4)**
- ☐ Diabetes Mellitus w/o complications **(E11.9)**
- ☐ Diabetic Nephropathy **(E11.21)**
- ☐ Diabetic CKD **(E11.22)**
  - ☐ CKD stage 3 **(N18.3)**
  - ☐ CKD stage 3A Moderate CKD (Unspecified) **(N18.30)**
  - ☐ CKD stage 3B Moderate CKD GFR = 45-59 mL/min) **(N18.31)**
  - ☐ CKD stage 3B Moderate CKD (GFR = 30-44 mL/min) **(N18.32)**
- ☐ CKD stage 4 **(N18.4)**
- ☐ CKD stage 5 **(N18.5)**
- ☐ Diabetic Neuropathy **(E11.42)**
- ☐ Diabetic Gastroparesis **(E11.43)**
- ☐ Diabetic Cataract **(E11.36)**
- ☐ Diabetic Macular Edema **(E11.311)**
- ☐ Diabetic Retinopathy **(E11.319)**
- ☐ Proliferative Diabetic Retinopathy **(E11.359)**
- ☐ Diabetic PVD **(E11.51)**
- ☐ Diabetic Gangrene **(E11.5)**
- ☐ **Diabetes w/other complications** **(E11.69)**
  - ☐ Diabetic Atherosclerosis **(I70.2x)**
  - ☐ Diabetic CAD **(I25.10)**
  - ☐ Diabetic CABG **(Z95.1)**
  - ☐ Diabetic s/p PTCA **(Z98.61)**
  - ☐ Diabetic Erectile Dysfunction **(N52.9)**
  - ☐ Diabetic Hyperlipidemia **(E78.5)**
  - ☐ Diabetic Onychomycosis **(B35.1)**
  - ☐ Diabetic Ulcer **(L89.x)** Location & Stage:
- ☐ Hyper- or Hypo- Parathyroidism **(E2x.x)**
- ☐ Malnutrition; specify: **(E4x)**
- ☐ Morbid Obesity (BMI>40) **(E66.01)**
  - ☐ BMI 40.0-44.9 **(Z68.41)**
  - ☐ BMI 45.0-49.9 **(Z68.42)**
  - ☐ BMI 50.0-59.9 **(Z68.43)**
  - ☐ BMI 60.0-69.9 **(Z68.44)**
  - ☐ BMI 70.0 & over **(Z68.45)**
- ☐ Obesity hypoventilation syndrome **(E66.2)**

Gastroenterology
- ☐ Alcoholic Liver Disease **(K70.9)**
- ☐ Chronic Hepatitis **(K73.9)**
- ☐ Chronic Viral Hepatitis **(B18.9)**
- ☐ Cirrhosis **(K74.60)**
- ☐ Fecal Impaction **(K56.41)**
- ☐ Crohn's Disease **(K50.90)**
- ☐ Ulcerative Colitis **(K51.90)**

Genitourinary System
- ☐ CKD 3 **(N18.3)**
- ☐ CKD 4 **(N18.4)**
- ☐ CKD 5 **(N18.5)**
- ☐ Dialysis Non-Compliance **(Z91.15)**
- ☐ ESRD **(N18.6)**
- ☐ 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)**

Oncology/Hematology **(C-code)**
- ☐ Cancer; type:

Adjuvant therapy: Y / N
Is patient opting out of treatment: Y / N
Mets: Y / N; specify:

Ophthalmology
- ☐ Glaucoma; type: _____ **(H40.1x)**

Pulmonary
- ☐ Asthma; severity: _____ **(J45.x)**
- ☐ Chronic Bronchitis **(J42)**
- ☐ Chronic Respiratory Failure (O_2Sat<88%) **(J96.10)**
- ☐ COPD/Chronic Obstructive Asthma **(J44.9)**
- ☐ Emphysema **(J43.9)**

Psychiatry
- ☐ Alcohol Dependence/Intoxication (even in remission) **(F10.20)**
- ☐ Substance Use Disorder (not valid if pt on pain management or under MD supervision) **(F11.xx-F19.xx)**
  - ☐ Opioid abuse, uncomplicated **(F11.10)**
  - ☐ Opioid dependence, uncomplicated **(F11.20)**
- ☐ Other psychoactive substance abuse, uncomplicated **(F19.10)**
- ☐ Bipolar Disorder **(F31.9)**
- ☐ Major Depression; Single Episode severity: _____ **(F32.x)**
- ☐ Major Depression; Recurrent Episode severity: _____ **(F33.x)**
- ☐ Schizophrenia **(F20.9)**

Rheumatology
- ☐ Osteoporosis **(M81.0)**
- ☐ Pathologic Vertebral Fx **(M48.57XA)**
- ☐ Rheumatoid Arthritis **(M06.9)**

Skin & Subcutaneous Tissue
- ☐ Non-Pressure Ulcer: Y / N Location: **(L97.x)**
- ☐ Pressure Ulcer: Y / N Location/Stage: **(L89.x)**

Status
- ☐ Amputation; site: ____ **(Z89.xxx)**
- ☐ Ostomy; type: _____ **(Z93.x)**
- ☐ Transplant; type: _____ **(Z94.x)**

Other
1.
2.
3.
4.
5.

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

Patient Name
DOB:
Next Due Date:

Gender:
Age:

Date of Service:
Race/Ethnicity:

FAMILY CHOICE ACO
PHYSICIAN-LED ACCOUNTABLE CARE ORGANIZATION

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 Hereditary Medical Events:	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

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

☐ 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.

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

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

FAMILY CHOICE ACO
PHYSICIAN-LED ACCOUNTABLE CARE ORGANIZATION

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
Falls: Screening for Future Fall Risk (2024) *(Adults 65+)*		Pt screened or assessed for history of falls: ☐ 0-1 falls ☐ 2 or more falls or *any* fall with injury	**1101F** (0-1 falls) **1100F** (2+ falls or any fall with injury)
***Diabetes Type 1 or 2:* HbA1c Poor Control >9.0%** (2023-2024) *(Adults 18-75)*		☐ Diabetes Type 1 or 2 diagnosis; *and* ☐ Most recent HbA1c result is:	**ICD-10 (Diabetes): Ell.___** **3046F** (most recent HbA1c >9.0%)
***Essential or Primary Hypertension:* Controlled BP <140/90 mmHg** HTN diagnosis w/in first 6 months of 2024 or before 2024, continuing into 2024. *(Adults 18-85)*		☐ Essential or Primary Hypertension diagnosis; *and* ☐ Most recent BP reading is:	**ICD-10 (HTN): I10** **G8752** (Systolic BP < 140mmHg) **G8754** (Diastolic BP < 90mmHg)
Major Depression/Dysthymia Remission (PHQ-9 < 5) at 12 mo. *(Adults 18+ or 12-17 y.o)*		☐ Major Depressive Disorder diagnosis; *or* ☐ Dysthymia Disorder diagnosis; *and* ☐ PHQ-9 >9 (11/1/20-10/31/21); *and* ☐ f/u PHQ-9 <5 at 12 months +/- 60 days	**ICD-10 (MDD): F33.____** **ICD-10 (Dysthymia): F34.1____** **G9509** (remission at 12 months)
Breast Cancer Screen (on or between 10/1/22-12/31/24) *(Women 50-74)*		☐ Report attached; *and* ☐ Normal ☐ Abnormal	**3014F** (results documented & reviewed)
Colorectal Cancer Screen (2024 or indicated timeframe) Fecal occult blood; *or* Flexible Sigmoidoscopy (2020-2024); *or* Colonoscopy (2015-2024); *or* CT colonography (2020-2024); *or* Fecal immunochemical DNA test (FIT-DNA) (2022-2024) *(Adults 50-75)*		☐ Report attached; *and* ☐ Normal ☐ Abnormal ☐ Normal ☐ Abnormal ☐ Normal ☐ Abnormal ☐ Normal ☐ Abnormal ☐ Normal ☐ Abnormal	**3017F** (screening results documented and reviewed)
Vaccinations Influenza (8/1/23-3/31/24) *(6mo+)*		☐ Influenza vaccine received ☐ Patient reported receipt of Influenza Immunization ☐ Patient declined Influenza Immunization	**G8482** (Influenza vaccine administered or previously received)
Tobacco Use: Screened at least once during 2024 and received cessation intervention (within the previous 12 months) if positive tobacco user *(Adults 18+)*		☐ 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 (2024) *(12 y.o+)*		☐ Negative PHQ-9 ☐ Positive PHQ-9 ☐ Follow-Up Plan if positive: referral for additional evaluation given for depression/medication/other intervention ☐ Patient refused Depression Screening	**G8431** (positive screening & f/u plan documented) **G8510** (negative screening documented, f/u plan not required)
Cardiovascular Disease: Previous or current diagnosis of ASCVD or ASCVD procedure Familial Hypercholesterolemia or fasting or direct LDL-C >= 190 mg/dL (Adults 20+); *or* Diabetes Type 1 or Type 2 (Adults 40-75) **Who were prescribed or were on Statin Therapy in 2024**		☐ Atherosclerosis Cardiovascular Disease or procedure; or ☐ Familial Hypercholesterolemia diagnosis; *or* ☐ LDL-C result is: ☐ *or* Diabetes Type 1 or Type 2 diagnosis (2022) ☐ *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:**
DOB: **Age:** **Race/Ethnicity:**
Next Due Date:

FAMILY CHOICE | ACO
PHYSICIAN-LED ACCOUNTABLE CARE ORGANIZATION

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:** _____
Print Name & Credentials: _ _____

Patient Name
DOB:
Next Due Date:

Gender:
Age:

Date of Service:
Race/Ethnicity:

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:**
DOB: **Age:** **Race/Ethnicity:**
Next Due Date:

FAMILY CHOICE ACO
PHYSICIAN-LED ACCOUNTABLE CARE ORGANIZATION

Office Use Only				
Six Item Cognitive Impairment Test (6CI)				
1	Ask patient to remember three words • **Apple** • **Table** • **Penny**	Make sure patient can repeat three words properly and inform him/her that you will ask to repeat later.	Yes	No
				Score
2	What year is this?	☐ Correct (0 pts.) ☐ Incorrect (3 pts.)		
3	What month is this?	☐ Correct (0 pts.) ☐ Incorrect (3 pts.)		
4	What is the day of the week?	☐ Correct (0 pts.) ☐ Incorrect (4 pts.)		
5	Repeat information from #1	☐ Correct (0 pts.) ☐ 1 error (3 pts.) ☐ 2 errors (4 pts.) ☐ 3 errors (6 pts.) ☐ 4 errors (8 pts.) ☐ All incorrect (10 pts.)		
		Add all scores for Total		

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: _ _____