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

FAMILY CHOICE ACO
PHYSICIAN-LED ACCOUNTABLE CARE ORGANIZATION

ANNUAL WELLNESS VISIT 2025 (FFS)

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

Reason for Appointment: ☐ Initial Annual Wellness Visit [**G-0438**] ☐ Subsequent Annual Wellness Visit[**G-0439**]

- Please use code **G-0438** if the encounter is the **first AWV** (this code can only be billed once).
- Please use code **G-0439** for **repeat AWV**.

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

Conditions		Conditions		Conditions	
Circulatory System		☐ CKD stage 4	**(N18.4)**	**Oncology/Hematology**	**(C-code)**
☐ AAA> 3cm	**(I71.4)**	☐ CKD stage 5	**(N18.5)**	☐ Cancer; type:	
☐ Aortic Tortuosity/Stricture/Ectasia	**(I77.819)**	☐ Diabetic Neuropathy	**(E11.42)**	Adjuvant therapy: Y / N	
☐ Atherosclerosis of Extremities; specify location and type: _____	**(I70.2x)**	☐ Diabetic Gastroparesis	**(E11.43)**	Is patient opting out of treatment: Y / N	
		☐ Diabetic Cataract	**(E11.36)**	Mets: Y / N; specify:	
☐ Atherosclerotic Hrt Dis of Native Coronary Artery or CABG w/Angina	**(I25.119)**	☐ Diabetic Macular Edema	**(E11.311)**	**Ophthalmology**	
		☐ Diabetic Retinopathy	**(E11.319)**	☐ Glaucoma; type: _____	**(H40.1x)**
☐ Atherosclerosis of Aorta	**(I70.0)**	☐ Proliferative Diabetic Retinopathy	**(E11.359)**	**Pulmonary**	
☐ Atherosclerosis of Renal Artery	**(I70.1)**			☐ Asthma; severity: _____	**(J45.x)**
☐ Peripheral Vascular Disease	**(I73.9)**	☐ Diabetic PVD	**(E11.51)**	☐ Chronic Bronchitis	**(J42)**
☐ Phlebitis and Thrombophlebitis of deep vessels of lower extremity	**(I80.209)**	☐ Diabetic Gangrene	**(E11.5)**	☐ Chronic Respiratory Failure (O_2Sat<88%)	**(J96.10)**
		☐ **Diabetes w/other complications**	**(E11.69)**		
☐ Varicose Veins with ulceration; location: _____	**(I83.0x)**	☐ Diabetic Atherosclerosis	**(I70.2x)**	☐ COPD/Chronic Obstructive Asthma	**(J44.9)**
		☐ Diabetic CAD	**(I25.10)**		
☐ Angina Pectoris; (even if controlled by meds)	**(I20.9)**	☐ Diabetic CABG	**(Z95.1)**	☐ Emphysema	**(J43.9)**
		☐ Diabetic s/p PTCA	**(Z98.61)**	**Psychiatry**	
☐ Atrial Fibrillation	**(I48.91)**	☐ Diabetic Erectile Dysfunction	**(N52.9)**	☐ Alcohol Dependence/Intoxication (even in remission)	**(F10.20)**
☐ Atrial Flutter	**(I48.92)**	☐ Diabetic Hyperlipidemia	**(E78.5)**		
☐ PSVT	**(I47.1)**	☐ Diabetic Onychomycosis	**(B35.1)**	☐ Substance Use Disorder (not valid if pt on pain management or under MD supervision)	**(F11.xx-F19.xx)**
☐ Sick Sinus Syndrome/SA Node Dysfunction	**(I49.5)**	☐ Diabetic Ulcer Location & Stage:	**(L89.x)**		
		☐ Hyper- or Hypo- Parathyroidism	**(E2x.x)**	☐ Opioid abuse, uncomplicated	**(F11.10)**
☐ Heart Failure; specify: _____	**(I50.x)**	☐ Malnutrition; specify:	**(E4x)**	☐ Opioid dependence, uncomplicated	**(F11.20)**
☐ Hyperlipidemia	**(E78.5)**	☐ Morbid Obesity (BMI>40)	**(E66.01)**		
☐ Hypertension: Essential (Primary)	**(I10)**	☐ BMI 40.0-44.9	**(Z68.41)**	☐ Other psychoactive substance abuse, uncomplicated	**(F19.10)**
☐ Hypertensive Heart Disease with Heart Failure	**(I11.0)**	☐ BMI 45.0-49.9	**(Z68.42)**		
		☐ BMI 50.0-59.9	**(Z68.43)**	☐ Bipolar Disorder	**(F31.9)**
☐ Hypertensive Heart Disease without Heart Failure	**(I11.9)**	☐ BMI 60.0-69.9	**(Z68.44)**	☐ Major Depression; Single Episode severity: _____	**(F32.x)**
		☐ BMI 70.0 & over	**(Z68.45)**		
☐ Hypertensive CKD Stage 1-4	**(I12.9)**	☐ Obesity hypoventilation syndrome	**(E66.2)**	☐ Major Depression; Recurrent Episode severity: _____	**(F33.x)**
☐ Hypertensive CKD Stage 5 or ESRD	**(I12.0)**	**Gastroenterology**			
☐ Hypertensive Heart Disease and CKD Stage 1-4 with Heart Failure	**(I13.0)**	☐ Alcoholic Liver Disease	**(K70.9)**	☐ Schizophrenia	**(F20.9)**
		☐ Chronic Hepatitis	**(K73.9)**	**Rheumatology**	
☐ Hypertensive Heart Disease and CKD Stage 1-4 without Heart Failure	**(I13.10)**	☐ Chronic Viral Hepatitis	**(B18.9)**	☐ Osteoporosis	**(M81.0)**
		☐ Cirrhosis	**(K74.60)**	☐ Pathologic Vertebral Fx	**(M48.57XA)**
☐ Hypertensive Heart Disease and CKD Stage 5 or ESRD without Heart Failure	**(I13.11)**	☐ Fecal Impaction	**(K56.41)**	☐ Rheumatoid Arthritis	**(M06.9)**
		☐ Crohn's Disease	**(K50.90)**	**Skin & Subcutaneous Tissue**	
☐ Hypertensive Heart Disease and CKD Stage 5 or ESRD with Heart Failure	**(I13.2)**	☐ Ulcerative Colitis	**(K51.90)**	☐ Non-Pressure Ulcer: Y / N Location:	**(L97.x)**
		Genitourinary System			
☐ Old MI (>8 weeks)	**(I25.2)**	☐ CKD 3	**(N18.3)**	☐ Pressure Ulcer: Y / N Location/Stage:	**(L89.x)**
☐ Primary Pulmonary Hypertension	**(I27.0)**	☐ CKD 4	**(N18.4)**		
☐ Secondary Hypertension	**(I15.9)**	☐ CKD 5	**(N18.5)**	**Status**	
Endocrinology/Metabolic		☐ Dialysis Non-Compliance	**(Z91.15)**	☐ Amputation; site: ____	**(Z89.xxx)**
☐ Long term Insulin use	**(Z79.4)**	☐ ESRD	**(N18.6)**	☐ Ostomy; type: _____	**(Z93.x)**
☐ Diabetes Mellitus w/o complications	**(E11.9)**	☐ Peritoneal Dialysis	**(Z49.01)**	☐ Transplant; type: _____	**(Z94.x)**
☐ Diabetic Nephropathy	**(E11.21)**	☐ Renal Dialysis	**(Z99.2)**	**Other**	
☐ Diabetic CKD	**(E11.22)**	**Neurology**		1.	
☐ CKD stage 3	**(N18.3)**	☐ Alzheimer's Disease	**(G30.x)**	2.	
☐ CKD stage 3A Moderate CKD (Unspecified)	**(N18.30)**	☐ Migraines; type: _____	**(G43.x)**	3.	
		☐ Old CVA; late effects: _____	**(I69.x)**	4.	
☐ CKD stage 3B Moderate CKD GFR = 45-59 mL/min)	**(N18.31)**	☐ Parkinson's Disease	**(G20)**	5.	
		☐ Seizure or Epilepsy	**(G40.x)**		
☐ CKD stage 3B Moderate CKD (GFR = 30-44 mL/min)	**(N18.32)**				

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

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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 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

_____
_____
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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.

Provider Signature: _____ **Date:** _____
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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
Falls: Screening for Future Fall Risk (2025) *(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%** (2024-2025) *(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 2025 or before 2025, continuing into 2025. *(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 (11/01/23-10/31/24); *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 10/1/23-12/31/25) *(Women 50-74)*		☐ Report attached; *and* ☐ Normal ☐ Abnormal	**3014F** (results documented & reviewed)
Colorectal Cancer Screen (2025 or indicated timeframe) Fecal occult blood; *or* Flexible Sigmoidoscopy (2021-2025); *or* Colonoscopy (2016-2025); *or* CT colonography (2021-2025); *or* Fecal immunochemical DNA test (FIT-DNA) (2023-2025) *(Adults 50-75)*		☐ Report attached*; and* ☐ Normal ☐ Abnormal ☐ Normal ☐ Abnormal ☐ Normal ☐ Abnormal ☐ Normal ☐ Abnormal ☐ Normal ☐ Abnormal	**3017F** (screening results documented and reviewed)
Vaccinations Influenza (08/01/2024 - 03/31/2025) Influenza (08/01/2025 - 12/31/2025) *(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 2025 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 (2025) *(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 2025**		☐ Atherosclerosis Cardiovascular Disease or procedure; or ☐ Familial Hypercholesterolemia diagnosis; *or* ☐ LDL-C result is: ☐ *or* Diabetes Type 1 or Type 2 diagnosis (2025) ☐ *and* Statin Therapy Rx	**G9664** (current statin therapy users or received a prescription for statin therapy)

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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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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:**

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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: _ _____