Annual Wellness Visit

HealthCare Partners

This form can be used to document your patients' Annual Wellness Visits (AWV). Required steps and pertinent codes have been included to aid in the process. Your personal progress notes, electronic medical records (EMR) or continuation sheet(s) can be used to supplement the form as needed.

Patient Name: _____ DOB: ____ /____ /____ Date of Service: ____ /____ /____

Age: _____ Sex: _____ Patient Phone: _____ Provider: _____

Emergency Contact Name/Number: _____ Marital Status: _____

Case ID: _____ HIC#: _____ MRN#: _____

1. LOCATION OF VISIT:

Provider Office ___ Home Setting ___ (PCP___/Vendor___) Skilled Nursing Facility ___

Telehealth ___ Audio & Video___ Audio Only ___Technology Platform _____

2. REASON FOR VISIT: _____

3. VITAL SIGNS: *(Required*)*

For claims/billing: Use ICD-10 Z68 XX for BMI/BMI Percentile.

*Weight: _____ *Height: _____ Temp: _____ Pulse rate: _____ Blood type: _____

*BP: _____ *BMI: _____ *(21 yrs. or older = actual BMI required; under 21 yrs. = Percentile)*

4. PAST INDIVIDUAL MEDICAL HISTORY: *Reviewed individual history with patient. Significant findings and/or changes were noted on patient's history form and include:*

See continuation sheet? __Yes __No

5. PAST FAMILY MEDICAL HISTORY: *Reviewed family history with patient. Significant findings and/or changes were noted on patient's history form and include:*

See continuation sheet? __Yes __No

6. PAST SURGICAL HISTORY: *Reviewed patient-completed individual surgical history with patient. Significant findings and/or changes were noted on patient's history form and include:*

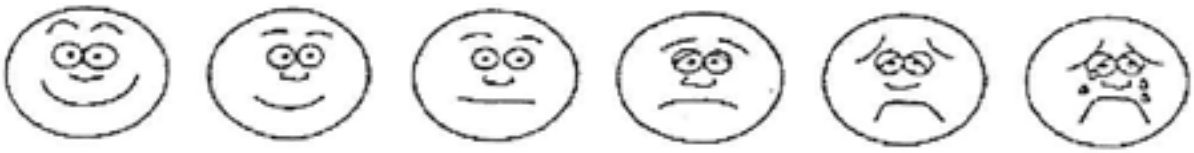
See continuation sheet? __Yes __No

Patient Name: _____ DOB: _____ /_____ /_____ Date of Service: _____ /_____ /_____

7. PAIN SCALE *(Required only for patients 66 years and older; both sections A & B must be completed) For claims/billing: Use CPT 1125F if pain level = 1-10 or CPT 1126F if pain = 0.*

A. Describe type of pain and location:

B. Notate with a check mark the number listed below that best describes the pain level:



0	2	4	6	8	10
No pain	Mild	Medium	High	Severe	Very severe
__	__	__	__	__	__

8. ADVANCE CARE PLANNING *(Required only for patients 66 years and older.)*
For claims/billing: Use CPT 1158F to report advanced care planning or CPT 1157F if an advance directive or similar legal document is present in the medical record.

Patient has an Advance Directive in place _____ Yes _____ No

End-of-life care was discussed during this visit _____ Yes _____ No

NOTES & PLAN:

Patient Name: _____ DOB: _____ /_____ /_____ Date of Service: _____ /_____ /_____

9. DEPRESSION SCREENING - Patient Health Questionnaire (PHQ – 9)

(If the answer to the 1st two questions is "0/Not at all", the survey is complete.)
(Please indicate N/A if this section cannot be administered for any reason and provide reason below.)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly Everyday	N/A
1. Little interest or pleasure in doing things	0	1	2	3	N/A [ ]
2. Feeling down, depressed, or hopeless	0	1	2	3	N/A [ ]
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3	N/A [ ]
4. Feeling tired or having little energy	0	1	2	3	N/A [ ]
5. Poor appetite or overeating	0	1	2	3	N/A [ ]
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3	N/A [ ]
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3	N/A [ ]
8. Moving or speaking so slowly that other people 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	N/A [ ]
9. Thoughts that you would be better off dead, or hurting yourself	0	1	2	3	N/A [ ]
Scoring					
TOTAL SCORE					

For scores higher than 0, how difficult have those problems made it for your patient to do work, take care of things at home, or get along with other people?

[ ] Not difficult at all [ ] Somewhat difficult [ ] Very difficult [ ] Extremely Difficult

Select the appropriate score: [ ] Minimal Depression (1-4); [ ] Mild Depression (5-9);
[ ] Moderate Depression (10-14); [ ] Moderately Severe Depression (15-19); [ ] Severe Depression (20-27)

Additional Comments:

Patient Name: _____ DOB: _____ /_____ /_____ Date of Service: _____ /_____ /_____

10. MEDICATION LIST: *Reviewed medication list with patient (prescriptions and non-prescriptions — including OTC, vitamins, home remedies and herbs) and updated. Significant findings and/or changes were noted on patient's medication list and include:*

Currently Active	Generic Drug Name	Qty. Dispensed	Days' Supply	Treatment for/ Prescribed by	Dose/ Frequency

COMMENTS: *(A separate medication list may be attached if needed and must include the patient's name, DOB, DOS and provider signature.)*

See continuation sheet? __Yes __No

For claims/billing: Use 1159F and G8427 to report the medication list was documented in the medical record, and 1160F to report the medications were reviewed with patient.

Patient does not take any medications: _____ Date: _____ /_____ /_____

ALLERGIES OR REACTIONS TO MEDICATIONS: *Reviewed patient-completed list of allergies with patient. Significant findings and/or changes were noted on patient's allergy list and include:*

See continuation sheet? __Yes __No

If the patient was hospitalized in the last 30 days, the following medications have been reconciled against pre-hospital medications:

For claims/billing: Use CPT 1111F to indicate discharge medications reconciled with current medication list.

Patient Name: _____ DOB: _____ /_____ /_____ Date of Service: _____ /_____ /_____

11. PREVENTIVE HEALTH COUNSELING

(Please notate/explain N/As if section cannot be completed for any reason.)

1.Improving and maintaining physical activity	Yes [ ]	No [ ]	N/A [ ]
2.Bladder control issues and treatment options	Yes [ ]	No [ ]	N/A [ ]
3. Fall risk and fall prevention (Is the patient's home safe, e.g. good lighting, handrails on stairs and bath, etc.?)	Yes [ ]	No [ ]	N/A [ ]
4.Improving and maintaining physical health	Yes [ ]	No [ ]	N/A [ ]
5.Improving and maintaining mental health	Yes [ ]	No [ ]	N/A [ ]
6. Does the patient handle his/her own medications?	Yes [ ]	No [ ]	N/A [ ]
7. Did you notice or did patient express any hearing difficulties?	Yes [ ]	No [ ]	N/A [ ]
8. Did you notice or did patient express any vision difficulties?	Yes [ ]	No [ ]	N/A [ ]
9. Were distance and reading eye charts used?	Yes [ ]	No [ ]	N/A [ ]
NOTES & PLAN: See continuation sheet? ___Yes ___ No			

Patient Name: _____ DOB: _____ /_____ /_____ Date of Service: _____ /_____ /_____

12. FUNCTIONAL ASSESSMENT* *(*Required only for patients who are 66 years and older.)*

Please indicate "1" or "0" in score field for each activity and whether patient has been counseled. Please add scores in the space provided for the Total Functional Score.

Activity	Score	Comments
CONTINENCE 0 = incontinent (or catheterized & unable to manage alone) 1 = independent		If 0, has patient been counseled?
MOBILITY/TRANSFERRING 0 = unable; help needed in moving from bed to chair or requires complete transfer; uses wheelchair 1 = moves in & out of bed unassisted (mechanical aids are acceptable)		If 0, has patient been counseled?
FEEDING 0 = needs partial or total help with feeding or requires parenteral feeding 1 = gets food from plate into mouth independently; prep of food may be done by another person		
BATHING 0 = needs help with bathing or getting in & out of the shower 1 = independent (bathes self completely; disabled extremity)		
DRESSING 0 = needs help with dressing self or needs to be completed dressed 1 = gets clothes from closet & puts on clothes complete with fasteners		
TOILET USE 0 = needs help transferring to the toilet; unable to clean self; uses bed pan or commode 1 = goes to toilet, gets on & off, cleans genital area without help		
WALKING 0 = needs help from another person with walking or completely unable to walk 1 = independent; able to walk by themselves or with cane or other assistive devices		
Total Functional Score		

(For claims/billing: Use CPT 1170F to report that the functional assessment was completed.)

Patient Name: _____ DOB: _____ /_____ /_____ Date of Service: _____ /_____ /_____

13. PREVENTIVE HEALTH REVIEW *(If a Required Population is not indicated, the review is required for all patients. All applicable answers must be completed.)*

IMMUNIZATIONS & SCREENINGS *(Counsel patients on importance of receiving during required timeframe)*

VACCINES

I. **Influenza** *(Required once each flu season)*
Has patient received vaccine in required timeframe? Y _____ N _____
If yes, date vaccine administered: _____ /_____ /_____
If no, has patient been counseled on the importance of vaccine? Y _____ N _____

II. **Pneumococcal Vaccine** *(Required for ages 65+ or high risk; 1 - 2 doses p/lifetime)*
Has patient received the vaccine? Y _____ N _____
If yes, date vaccine administered: _____ /_____ /_____ (PCV13)
_____ /_____ /_____ (PPSV23)
If no, has patient been counseled on the importance of the vaccine? Y _____ N _____

SCREENINGS

III. **Colon/Colorectal Cancer** *(Required for ages 50 – 75)*
Indicate whether patient has received one of the following screenings w/in required timeframe:

- FIT/FOBT/gFOBT Test _____ *(min. 1x in current calendar year)* OR
- FIT-DNA (Cologuard®) _____ *(min. 1x in current year or preceding 2 calendar years)* OR
- Flexible Sigmoidoscopy _____ *(min. 1x in current or preceding 4 calendar years)* OR
- CT Colongraphy _____ *(min. 1x in current or preceding 4 calendar years)* OR
- Colonoscopy _____ *(min. 1x in current or preceding 9 calendar years)*

Date of screening: _____ /_____ /_____ Result: _____

If referred to a Specialist: Name: _____ Date: _____ /_____ /_____ OR

Patient had total colectomy so doesn't need to be screened: Date: _____ /_____ /_____ OR

N/A _____ Unable to complete because _____

Patient has history of colon/colorectal cancer? Y _____ N _____
Date Diagnosed: _____ /_____ /_____

Patient Name: _____ DOB: _____ /_____ /_____ Date of Service: _____ /_____ /_____

IV. Bilateral Mammogram: *(Females aged 50 – 74)*
(minimum 1x in current year or from October 1st of 2 preceding calendar years)

Patient completed bilateral mammogram _____ /_____ /____ Result: _____
OR
Bilateral mammogram ordered: _____ /_____ /____
OR
Patient had a bilateral mastectomy and does not need to be screened _____ /_____ /____
OR
N/A _____ Unable to complete because _____

V. Bone Mineral Density Test for Osteoporosis Management:
(Female aged 65 or older; minimum 1x following 65th birthday)

A. Bone Mineral Density Testing

Bone mineral density test completed: _____ /_____ /____ Result: _____
OR
Bone mineral density test ordered: _____ /_____ /____
OR
Patient has osteoporosis diagnosis; currently on medication:
Prescription: _____ Date prescribed: _____ /_____ /____
OR
N/A _____ Unable to verify or complete because _____

B. Post non-traumatic fracture? *(test or prescription required within 6 months)*

N_____ Y_____ Fracture Date: _____ /_____ /____ Bone Density Test: _____ /_____ /____
Prescription: _____ Date prescribed: _____ /_____ /____

VI. Diabetes *(if no, skip to VIIA)* - HbA1c Test: *(min. 1x per calendar year if diabetic)*

A. HbA1c Test: N_____ *(if no, skip to VIIA)* Y_____ Date: _____ /_____ /_____
Result: _____
OR
Ordered HbA1c Test: _____ /_____ /_____
OR
Referred to a Specialist: Name: _____ Date: _____ /_____ /_____
OR
N/A _____ Unable to verify test or refer because _____

B. Diabetic Retinol or Dilated Eye Exam: *(min. 1x in current calendar year if previously diagnosed with retinopathy or 1x in current or previous calendar year if negative)*

Patient already completed test on _____ /_____ /_____Result: _____
Vision Care Provider Name: _____ Address: _____
OR
Referred for eye exam: _____ /_____ /_____ Ophthalmologist or Optometrist: _____
OR
N/A _____ Unable to test or refer because _____

Patient Name: _____ DOB: _____ /_____ /_____ Date of Service: _____ /_____ /_____

C. Nephropathy Test (if diabetic - *min. 1x per calendar year)*

Date:_____ /_____ /_____ Results: Name: _____

OR

Ordered nephropathy screening or monitoring test on _____ /_____ /_____

OR

Referred to nephrologist on _____ /_____ /_____ Name: _____

OR

Patient currently on ACE/ARB Medication: Name: _____

OR

Patient has diagnosis of ESRD: Diagnosed on: _____ /_____ /_____

OR

N/A _____ Unable to test or refer because _____

VII. Rheumatoid Arthritis:

A. Does patient have rheumatoid arthritis? N___ *(if no, skip to section VIII)*; Y___

B. Was a disease modifying anti-rheumatic drug (DMARD) dispensed?

N___ Reason: _____

Y___ Prescription name: _____ Date:_____ /_____ /_____

VIII. Statin Therapy for Diabetes:

A. Does patient have diabetes? N___ *(if no, skip to section IX)* Y___

B. Was a statin medication dispensed?

N___ Reason: _____

Y___ Prescription name: _____ Date:_____ /_____ /_____

IX. Statin Therapy for Cardiovascular Disease:

A. Does patient have cardiovascular disease? N___ *(if no, skip to next section)*; Y___

B. Was a statin medication dispensed?

N___ Reason: _____

Y___ Prescription name: _____ Date:_____ /_____ /_____

Patient Name: ________________________ DOB:_____ /_____ /_____ Date of Service: _____ /_____ /_____

14. ASSESSMENT AND TREATMENT PLAN *(Provide justification for new diagnosis and provide treatment plan for all. Include additional documentation in an attached progress note.)*

Diagnosis Description	Status (check 1 only)	Treatment Plan
	Indicate the status of assessed diagnosis: [ ] Worsening [ ] Improving [ ] Stable Prior Rendering Provider:	
	Indicate the status of assessed diagnosis: [ ] Worsening [ ] Improving [ ] Stable Prior Rendering Provider:	
	Indicate the status of assessed diagnosis: [ ] Worsening [ ] Improving [ ] Stable Prior Rendering Provider:	
	Indicate the status of assessed diagnosis: [ ] Worsening [ ] Improving [ ] Stable Prior Rendering Provider:	
	Indicate the status of assessed diagnosis: [ ] Worsening [ ] Improving [ ] Stable Prior Rendering Provider:	
	Indicate the status of assessed diagnosis: [ ] Worsening [ ] Improving [ ] Stable Prior Rendering Provider:	

Other Conditions				
Description	**Active**	**Status (if active, check one)**	**Not Present**	**Inconclusive**
		[ ] Stable [ ] Improving [ ] Worsening		
		[ ] Stable [ ] Improving [ ] Worsening		
		[ ] Stable [ ] Improving [ ] Worsening		

Patient Name: _____ DOB: _____ /_____ /_____ Date of Service: _____ /_____ /_____

15. BASED ON YOUR EVALUATION:

(Reason for referring your patient to Case Management, if applicable.)

16. COMPLETED BY: ***(Required**********)***

Provider warrants that by signing below, all the information contained in this document is truthful and accurate. HealthCare Partners, IPA reserves the right to validate and code any diagnosis made by the Provider.

Provider Name (Print)*: _____

Provider Signature*: _____

Credentials*: MD___ DO___ NP___ PA___

Provider NPI Number*: _____

Date:_____ /_____ /_____ Clinical or Vendor Name: _____ Phone: _____