

Please update during patient visits and include in the patient's chart. CPT codes are included with each section.

Patient name:			Date of birth:
Member ID number:	Height:	Weight:	Calculated BMI:
		lbs.	

Advance directives — 1157F, 1158F, 99497, S0257

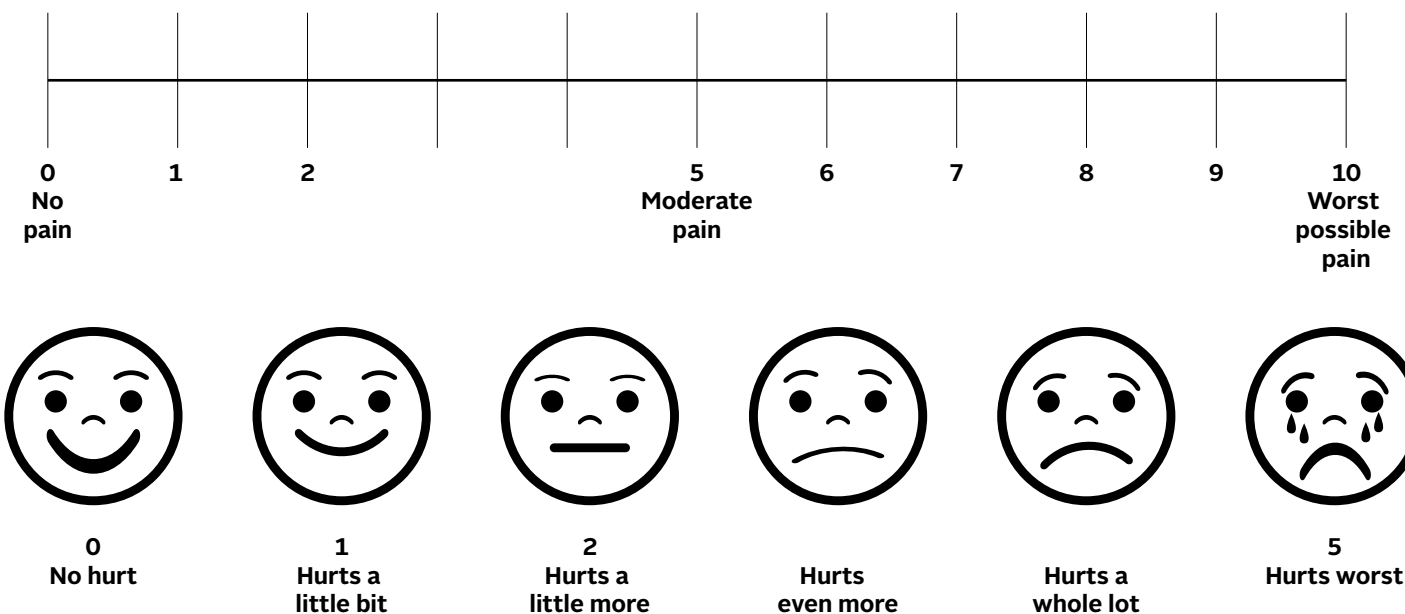
Date reviewed:	Notes:
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1. Patient has advanced directives: Yes No
2. Patient has living will: Yes No
3. Patient has surrogate decision maker: Yes No
4. Patient has actionable medical orders: Yes No
5. Patient has discussed with caregiver: Yes No
6. Patient has copy of advance care plan in chart: Yes No

Pain assessment — 0521F, 1125F, 1126F

Date	Pain (Yes/No)	Description of pain	Pain severity (0 – 10)	Treatment plan

Pain score 0 – 10 numerical rating



Care for Older Adults (COA) Form

Functional assessment — 1170F

ADL	Cognition	Ambulation	Speech	Vision	Hearing
<input type="checkbox"/> Independent <input type="checkbox"/> Minimal assistance <input type="checkbox"/> Needs assistance <input type="checkbox"/> Dependent on others	<input type="checkbox"/> Oriented x3 <input type="checkbox"/> Oriented x2 <input type="checkbox"/> Oriented x1 <input type="checkbox"/> Not oriented	<input type="checkbox"/> Independent <input type="checkbox"/> Non-ambulatory <input type="checkbox"/> Uses DME: <input type="checkbox"/> Scooter <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Wheelchair	<input type="checkbox"/> Unimpaired <input type="checkbox"/> Impaired <input type="checkbox"/> Language barrier	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Impaired: <input type="checkbox"/> Glasses or contacts <input type="checkbox"/> Blind	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Impaired: <input type="checkbox"/> Hearing aid or hearing device <input type="checkbox"/> Deaf
Notes:	Notes:	Notes:	Notes:	Notes:	Notes:

Medication review — 1159F, 1160F, G8427

Medication review and list of medications must be submitted on the same date. This may be completed by the prescribing practitioner or a clinical pharmacist.

Medication name and strength	Quantity/days' supply	Prescriber	Notes

Date:	Allergies:		
Adherence or other issues:		Over-the-counter (OTC) medications:	
Name and credentials of reviewer:		Signature:	

Provider name:	Provider signature:
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