Patient Name: _____ DOB: _____ Chart # _____
Last First MI DR/NP: _____
Date: _____ Location: _____

Medicare Well Patient Visits

Sex: M F	____ IPPE Welcome to Medicare (G0402) (1 time during first 12 months of coverage)	____ Initial AWV (G0438) (1 in a life time after coverage for 1 year)	_____ Subsequent AWV (G0439) (each year after initial well visit)

Medicare Eligibility Date:	Date of last Exam:	Date of last IPPE or AWV:	**AWV HRA Comments:**

Interpreter or other accommodation provided today: (describe)	Gravida/para:	Year of menopause:

Vital signs	VA:	Ht:	Wt:	BP:	BMI:	Waiste:	P/R:

LIST OF CURRENT PROVIDERS		**LIST OF CURRENT SUPPLIERS**	
Name	**Specialty**	**Name of Supplier**	**Item Supplied**

MEDICAL HISTORY			
Problem List:		**Medications:**	

SOCIAL HISTORY

Tobacco [ ]Current Type: Freq: [ ]2nd Hand [ ]Never [ ]Prior Use Quit date:

ETOH [ ]Never [ ]Occasional [ ]Daily
History of ETOH: (describe)

Caffeine [ ]Never [ ]Occasional [ ]Daily

Drug Abuse [ ]Never [ ]Occasional [ ]Daily [ ]Prior Use Quit date:
History of drug abuse: (describe)

Occupation: Exercise type/frequency:

Home environment [ ] Private home [ ] Assisted living [ ] Other: (describe)

FAMILY HISTORY - Use a check mark to indicate positive history

	Self	Father	Mother	Sisters	Brothers	Aunts	Uncles	Daughters	Sons
Deceased									
Hypertension									
Heart disease									
Stroke									
Kidney disease									
Obesity									
Genetic disorder									
Alcoholism									
Liver disease									
Depression									
Manic depressive									
Colon or rectal cancer									
Breast cancer									
Other cancer									
Other:									

DEPRESSION AND MOOD SCREEN – PHQ-9		
Provider has reviewed results from PHQ-9 Form	[ ] Yes	[ ] No
Additional comments or observation:		

FUNCTIONAL ABILITY AND LEVEL OF SAFETY SCREEN		
Was the patient's timed "Up & Go" test unsteady or longer than 30 seconds?	[ ] Yes	[ ] No
Do you need help with the phone, transportation, shopping, preparing meals, housework, laundry, meds or managing money?	[ ] Yes	[ ] No
Does your home have rugs in the hallway; lack grab bars in the bathroom; lack handles on the stairs or have poor lighting?	[ ] Yes	[ ] No
Do you live alone?	[ ] Yes	[ ] No
Has anyone tried to cause you physical harm in the last two months?	[ ] Yes	[ ] No
Have you noticed any hearing difficulties?	[ ] Yes	[ ] No
Hearing Evaluation:		

EVALUATION OF COGNITIVIE IMPAREMENT		
Mood/Affect:		
Appearance:		
Family member/caregiver input:		
Due to suspected cognitive functional decreases a mini mental exam was performed	[ ] Yes	[ ] No

REFERRALS BASED ON ABOVE INFORMATION PROVIDED BY PATIENT		
Based on the screening questions on page 1 and 2, the following additional evaluations are needed:		
Evaluation / Referral based on screening	Scheduled appointment with	Notes

END OF LIFE PLANNING		
Patient already has executed an Advance Directive.	[ ] Yes	[ ] No
In no, patient was given an opportunity to discuss and execute an Advance Directive today.	[ ] Yes	[ ] No
Provider assisted patient with and completed an Advanced Care Plan.	[ ] Yes	[ ] No
Provider is willing to follow the patient's wishes as expressed in the Advance Directive.	[ ] Yes	[ ] No
Additional information available at www.aging.dhr.georgia.gov		

PERSONALIZED HEALTH ADVICE WITH FURTHER EDUCATION & COUNSELING

IPPE EKG Results:

POTENTIAL RECOMMENDATIONS NOT COVERED AS MEDICARE PART B PREVENTIVE SERVICES	
Varicella vaccine	Aspirin therapy
Zoster vaccine	Calcium supplement
Tdap	Social services
Td vaccine	Dietary counseling
MMR vaccine	
Meningococcal vaccine	
Hepatitis A Vaccine	

HANDOUTS REVIEWED AND DISCUSSED WITH PATIENT

Providers' Signature:

COUNSELING AND REFERRALS FOR OTHER PREVENTIVE SERVICES – 5 to 10 year plan of care		
Preventive Service	**Recommendation**	**Scheduled**
Vaccines • Pneumococcal • Influenza • Hepatitis B (if medium/high risk)		
Mammogram • Aged 35 through 39: One baseline • Aged 40 and older: Annually		
Pap and Pelvic Examination • Annually if at high risk for developing cervical or vaginal cancer, or childbearing age with abnormal Pap test within past 3 years • Every 24 months for all other women		
Prostate Cancer Screen • All male Medicare beneficiaries aged 50 and older (coverage begins the day after 50th birthday)		
Colorectal Screening • FOBT every year • Flexible Sigmoidoscopy once every 4 years, or 120 months after a previous Screening Colonoscopy for people not at high risk • Screening Colonoscopy every 10 years (every 24 months for high risk), or 48 months after a previous Flexible Sigmoidoscopy • Barium Enema (as an alternative to a covered Flexible Sigmoidoscopy) every 48 months, and every 24 months for high risk		
Diabetes Self Management Training • Up to 10 hours of initial training within a continuous 12-month period • Subsequent years: Up to 2 hours of follow-up training each year after the initial year • Foot – refer to Podiatry • Eye – refer to Ophthalmologist		
Medical Nutritional Therapy (Diabetes and Renal Disease) • First year: 3 hours of one-on-one counseling • Subsequent years: 2 hours		
Bone Mass Measurement (Age 65 and over, biennial) • Women determined to be estrogen deficient and at clinical risk for osteoporosis; • Individuals with vertebral abnormalities; • Individuals receiving (or expecting to receive) glucocorticoid therapy for more than 3 months; • Individuals with primary hyperparathyroidism; or • Individuals being monitored to assess response to FDA-approved osteoporosis drug therapy.		
Glaucoma Screening • Medicare beneficiaries with diabetes mellitus, family history of glaucoma, African-Americans aged 50 and older; or • Hispanic-Americans aged 65 and older		
Cardiovascular Screening • Lipid every 5 years		
Diabetes Screen • Two screening tests per year for beneficiaries diagnosed with pre-diabetes • One screening per year if previously tested, but not diagnosed with pre-diabetes, or if never tested		
Abdominal Aortic Aneurysm Screening • Eligible beneficiaries must receive a referral at the time of an IPPE		
HIV Screening • Annually for beneficiaries at increased risk • Three times per pregnancy for beneficiaries who are pregnant: • First, when a woman is diagnosed with pregnancy; • Second, during the third trimester; and • Third, at labor, if ordered by the woman's clinician		
Tobacco Cessation Counseling • Two cessation attempts per year; each attempt includes a maximum of four intermediate or intensive sessions, up to eight sessions in a 12-month period		
Next Well Visit (12 months)		
Provider's Signature:		