

Wellcare Member Wellness



COMPREHENSIVE ASSESSMENT FORM

Member Last Name _____ DOB (MM/DD/YYYY) _____
Member First Name _____ DOS (MM/DD/YYYY) _____
Member ID _____ Native Language _____ Gender M / F _____
Rendering Provider _____ NPI _____
Member's PCP _____

Physical Exam: Vital Signs

Height (in) _____ BMI _____ HR _____ SBP _____ Spo2 _____
Weight (lbs.) _____ Temp (F°) _____ RR _____ DBP _____

Allergies: No known drug allergies No known food allergies

Medications: (List all medications including OTCs with dosage and frequency or attach a printed, signed and dated list and check here:

1159F — Medication List No Current Medications

1.	13.
2.	14.
3.	15.
4.	16.
5.	17.
6.	18.
7.	19.
8.	20.
9.	21.
10.	22.
11.	23.
12.	24.

1160F — Medication List Review

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider Credentials: MD, DO, PA, NP

Surgical History Reviewed and No Surgeries

Member Name: _____

DOB: _____

DOS: _____

Previous Procedures and Outcomes:

(Enter the most recent DOS and results for each)

	Date	Results		Date	Results
Colorectal Cancer Screening	-----	-----	Nephropathy Screening	-----	-----
Colonoscopy	-----	-----	Microalbuminuria	-----	-----
FIT DNA/ Cologuard	-----	-----	Macroalbuminuria	-----	-----
FOBT	-----	-----	HbA1C	-----	-----
Flexible Sigmoidoscopy	-----	-----	Retinal Eye Exam	-----	-----
Bone Mineral Density Test	-----	-----	Eye Care Provider Name	-----	-----
Mammogram	-----	-----	Pneumococcal Vaccine	-----	-----
Pap Smear	-----	-----	Shingles Vaccine	-----	-----
Influenza Vaccine	-----	-----			

Family History: Reviewed and No Relevant History

	Father	Mother	Children	Siblings	Grandparents
HTN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Lipids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Father	Mother	Children	Siblings	Grandparents
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Review of Systems: **Negative** **Positive/Findings**

General	<input type="checkbox"/>	
HEENT	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	
Digestive/GI	<input type="checkbox"/>	
GU	<input type="checkbox"/>	
Lymphatic/Hematologic	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	
Nervous	<input type="checkbox"/>	
Endocrine	<input type="checkbox"/>	
Emotional/Psychiatric	<input type="checkbox"/>	
Social History	<input type="checkbox"/> No <input type="checkbox"/> Yes	

Member Name: _____

DOB: _____ DOS: _____

1170F — Functional Assessment

Cognitive Status:	<input type="checkbox"/> Excellent <input type="checkbox"/> Diminished <input type="checkbox"/> Dementia <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Parkinson <input type="checkbox"/> Other:
Ambulatory Status:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Able to Climb Stairs <input type="checkbox"/> Walks With Cane <input type="checkbox"/> Uses Wheelchair/Scooter <input type="checkbox"/> Needs Assistance <input type="checkbox"/> Amputation R/L <input type="checkbox"/> Prosthetic Devices:
Hearing:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Deaf <input type="checkbox"/> Hearing Aids or Devices:
Vision:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Uses Glasses <input type="checkbox"/> Uses Contacts <input type="checkbox"/> Cataract(s) <input type="checkbox"/> Glaucoma R/L <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> DM Retinopathy <input type="checkbox"/> Blind
Speech:	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Other Functional Independence:	(Exercise, ability to perform job, etc.):
Smell/Taste:	<input type="checkbox"/> Normal <input type="checkbox"/> Some Changes
Touch:	<input type="checkbox"/> Intact <input type="checkbox"/> Decreased sensitivity (Hot/Cold) <input type="checkbox"/> Numbness:

Activities of Daily Living

	I = Independent	A = Assistance Needed	D = Dependent
Grooming	I	A	D
Dressing	I	A	D
Bathing	I	A	D
Eating	I	A	D
Transferring	I	A	D
Use of Toilet	I	A	D
Walking	I	A	D

Advance Care Planning (CPT II 1123F, 1124F, 1157F, 1158F; CPT 99497, 99498)

Advance Care Planning discussed: Yes No

Copy of Advance Care in the chart: Yes No

Patient has: Advance Directive Living Will Actionable Medical Orders Surrogate Decision Maker

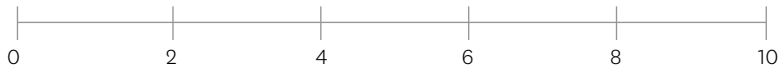
Pain Assessment:

Pain: No - 1126F Yes - 1125F Date of Onset: _____

Member Name: _____

DOB: _____

DOS: _____



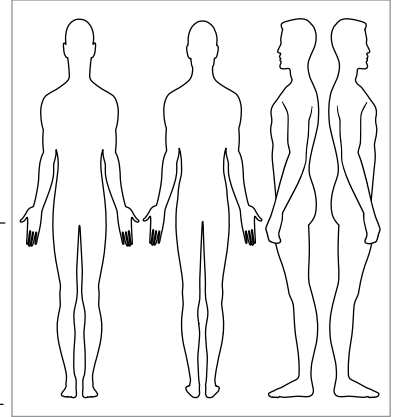
Intensity:

No Pain Mild Moderate Severe Very Severe Worst Pain

Location: _____

Frequency: Acute Chronic Intermittent Continuous Occasionally

Type of Pain: Aching Crushing Sharp Stabbing Throbbing Radiating
 Burning Tingling Cramping Other: _____



Patient/Family Education provided: Yes No Psychological Support: Yes No Under Pain Management: Yes No

If yes to Pain Management, Dr.: _____ Comments: _____

Fall Risk Screening: (Mark all that apply)

Unable to perform exam b/c of:

<input type="checkbox"/>	Diagnoses (3 or more existing)	<input type="checkbox"/>	Polypharmacy (4 or more medications, incl. OTC)
<input type="checkbox"/>	Prior history of falls within 3 months	<input type="checkbox"/>	Pain affecting level of function
<input type="checkbox"/>	Incontinence	<input type="checkbox"/>	Cognitive Impairment
<input type="checkbox"/>	Visual Impairment	<input type="checkbox"/>	Unable to rise from seat w/o U.E.
<input type="checkbox"/>	Impaired functional mobility	<input type="checkbox"/>	Increased Fall Risk (4 or more boxes marked)
<input type="checkbox"/>	Environmental Hazard		

TOTAL number of boxes marked: _____

Depression Screening:

<input type="checkbox"/> Unable to perform exam because the patient is unable to communicate/answer.	
Have you felt depressed or down-and-out over the past 2 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a loss of interest in things that normally bring you pleasure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you felt fatigued or had a loss of energy recently?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If two or more "Yes" then complete and document results from either a: <input type="checkbox"/> PHQ9 form <input type="checkbox"/> Standard Screening Tool <input type="checkbox"/> Clinical Interview	
Attach Standard Screening Tool or Clinical Interview to assessment if completed.	

Member Name: _____

DOB: _____ DOS: _____

Urinary Incontinence Screening:

Unable to perform exam because the patient is unable to communicate/answer.

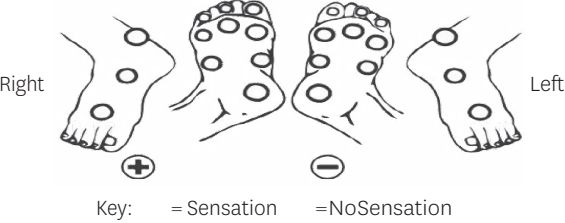
During the last 3 months, have you leaked urine (even a small amount)? Yes No

If Yes, please distribute education material.

Physical Exam:

	Normal	Abnormal/Findings		Normal	Abnormal/Findings
General	<input type="checkbox"/>		Rectal	<input type="checkbox"/>	<input type="checkbox"/> Deferred
HEENT	<input type="checkbox"/>		Pelvis/GU	<input type="checkbox"/>	<input type="checkbox"/> Deferred
Mouth	<input type="checkbox"/>		Skin	<input type="checkbox"/>	
Neck	<input type="checkbox"/>		Musculoskeletal	<input type="checkbox"/>	
Chest	<input type="checkbox"/>		Pulses	<input type="checkbox"/>	
Heart	<input type="checkbox"/>		Neurologic	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>		Psychiatric	<input type="checkbox"/>	
Breasts	<input type="checkbox"/>		Other	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>				

Foot Exam (please complete for all patients with Diabetes, Neuropathy, or PAD)

1. Symptoms <input type="checkbox"/> Burning, tingling, numbness in feet <input type="checkbox"/> Pain or cramping in calf area during exercise	<input type="checkbox"/> Previous foot ulcer <input type="checkbox"/> None of these		
2. Inspection <input type="checkbox"/> Infection <input type="checkbox"/> Calluses or corns <input type="checkbox"/> Nail disorders <input type="checkbox"/> Ulceration <input type="checkbox"/> Skin breaks <input type="checkbox"/> Foot deformity <input type="checkbox"/> None of these			
3. Pulses			
Dorsalis pedis:	<input type="checkbox"/> Normal <input type="checkbox"/> Weak <input type="checkbox"/> Absent		<input type="checkbox"/> Normal <input type="checkbox"/> Weak <input type="checkbox"/> Absent
Posterior Tibial:	<input type="checkbox"/> Normal <input type="checkbox"/> Weak <input type="checkbox"/> Absent		<input type="checkbox"/> Normal <input type="checkbox"/> Weak <input type="checkbox"/> Absent
4. Evidence of Neuropathy:	<input type="checkbox"/> Left Monofilament <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Right Monofilament <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
5. Complications Noted (check all that apply):	<input type="checkbox"/> Ulcer <input type="checkbox"/> Gangrene <input type="checkbox"/> Peripheral neuropathy <input type="checkbox"/> Peripheral vascular disease <input type="checkbox"/> None of these		

Member Name: _____

DOB: _____ DOS: _____

Treatment Plan: (Document all chronic or acute conditions, and comment on current status.)

Status Key: **AE** = Acute Exacerbation **AC** = Active Controlled **AU** = Active Uncontrolled **ES** = End Stage **RS** = Resolved

No.	Diagnosis	Status	Plan
1.			
2.			
3.			
4.			
5.			
6.			
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11.			
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14.			
15.			
16.			
17.			
18.			
19.			
20.			

Provider Signature: _____

Provider Printed Name: _____ Provider Credentials: MD, DO, PA, NP

