Patient Name: _____ **DOB:** _____ **Chart #**_____

            Last   First   MI

Medicare Well Patient Visits

Type of Wellness Exam:	___IPPE – Welcome to Medicare – Select G0402, G0403, G0404 or G0405 *(1 time during first 12 months on Medicare)*		___Initial AWV w/PPPS – G0438 *(1 time only after 1st 12 months of Medicare B eligibility AND 1 year after IPPE.)*		___Subsequent AWV w/PPPS – G0439 *(Annually at least 12 months after Initial AWV w/PPPS)*	
Medicare Part B Eligibility Date:		Date of Last Exam:		Date of Last IPPE or AWV:	Sex:	Date:
Vital signs:	Ht:	Wt:	Waist" or BMI:	BP: Temp:	Pulse Rate:	Blood Type:
Special Accommodations Needed:						

___Reviewed patient-completed **individual and family history** with patient. Significant findings and/or changes were noted on patient's history form and include (Pay close attention to opioid use disorders (OUD) – see Opioid Risk Tool:

See continuation sheet? _____Yes_____No

____Reviewed patient-completed **social history** with patient. Significant findings and/or changes were noted on patient's social history form and include (see smoking cessation section on page 7):

See continuation sheet? _____Yes_____No

___Reviewed patient's **chronic and acute problem list and risk factors** with patient. Significant findings and/or changes were noted on patient's problem list and include:

Educational materials were given to and discussed with patient: _____Yes ____No
If yes, describe:
Screenings, testing and referrals recommended and noted on patient's personalized schedule of health services. _____Yes ____No
See continuation sheet? _____Yes_____No

Patient Name: _____ **DOB:** _____ **Chart #**_____

               Last   **First**   **MI**

___Reviewed patient-completed list of **providers and suppliers** regularly involved in patient's care was with patient.   Significant findings and/or changes were noted on patient's provider and supplier list and include:

See continuation sheet? _____Yes_____No

___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

___Reviewed **medication list** with patient and updated. Significant findings and/or changes were noted on patient's medication list and include:

See continuation sheet? _____Yes_____No

___Reviewed **hospitalization list** with patient and updated. Significant findings and/or changes were noted on patient's hospitalization list and include:

See continuation sheet? _____Yes_____No

Patient Name: _____ **DOB:** _____ **Chart #**_____

                 Last,   **First**   **MI**

Assessment of any Cognitive Impairment:

General appearance:
Mood/affect:
Input from others:
Patient cognitive impairment tested with **CANS-MCI®** _____Yes ____No (If Yes remember 96103 & 96120)
If yes, results:
Notes and plan:
See continuation sheet? _____Yes_____No

Depression Screening:

Over the past two weeks, the patient expresses little interest or pleasure in doing things: _____Yes _____No
Over the past two weeks the patient felt down, depressed or hopeless: _____Yes _____No
Notes and plan:
See continuation sheet? _____Yes_____No

Functional Ability:

Does the patient exhibit a steady gait? _____Yes _____No
How long did it take the patient to get up and walk from a sitting position?
Is the patient self reliant? *(i.e. can he/she do own laundry, prepare meals, do household chores)* _____Yes _____No
Does the patient handle his/her own medications? _____Yes _____No
Does the patient handle his/her own money? _____Yes _____No
Is the patient's home safe *(i.e. good lighting, handrails on stairs and bath, etc.)*? _____Yes _____No
Did you notice, or did patient express any hearing difficulties? _____Yes _____No
Did you notice of did patient express any vision difficulties? _____Yes _____No
Were distance and reading eye charts used? _____Yes _____No
Notes and plan:
See continuation sheet? _____Yes_____No

Patient Name: _____ **DOB:** _____ **Chart #**_____

       Last,   **First**   **MI**

Advance Care Planning: (*At discretion of patient)*

Patient was offered the opportunity to discuss advance care planning: _____Yes _____No
Does patient have an Advance Directive: _____Yes _____No
If no, did you provide information on Caring Connections? _____Yes _____No
Notes and plan:
See continuation sheet? _____Yes_____No

EKG Results: (*Not mandatory)*

See continuation sheet? _____Yes_____No

Other Relevant Findings:

Patient Name: _____ **DOB:** _____ **Chart #**_____

Last,   First   MI

Notes and plan:
See continuation sheet? _____Yes_____No

Provider's Signature: _____Date: _____

Schedule of Personalized Health Plan
(Provide Copy to Patient)

Service	Medicare Coverage Requirements	Date of Most Recent Service	Provider Recommendation	Date Scheduled
Vaccines • Pneumococcal (once after 65) • Influenza (annually) • Hepatitis B (if medium/high risk)	Medium/high risk factors: End stage renal disease Hemophiliacs who received Factor VIII or IX concentrates Clients of institutions for the mentally retarded Persons who live in the same house as a HepB virus carrier Homosexual men Illicit injectable drug abusers			
Mammogram (biennial age 50-74)	Annually (age 40 or over)			

Patient Name: _____ **DOB:** _____ **Chart #**_____

               Last,   **First**   **MI**

Pap and pelvic exams (up to age 70 and after 70 if unknown history or abnormal study last 10 years)	Every 24 months except high risk			
Prostate cancer screening (annually to age 75) Digital rectal exam (DRE) Prostate specific antigen	Annually (age 50 or over), DRE not paid separately when covered E/M service is provided on same date			
Colorectal cancer screening (to age 75) • Fecal occult blood test (annual) • Flexible sigmoidoscopy (5y) • Screening colonoscopy (10y) • Barium enema				
Diabetes self-management training (no USPSTF recommendation)	Requires referral by treating physician for patient with diabetes or renal disease. 10 hours of initial DSMT sessions of no less than 30 minutes each in a continuous 12-month period. 2 hours of follow-up DSMT in subsequent years.			
Bone mass measurements (age 65 & older, biennial)	Requires diagnosis related to osteoporosis-sis or estrogen deficiency. Biennial benefit unless patient has history of long-term glucocorticoid use or baseline is needed			
Glaucoma screening (no USPSTF recommendation)	Diabetes mellitus, family history African American, age 50 or over Hispanic American, age 65 or over			

Patient Name: _____ DOB: _____ Chart #_____

             Last,   **First**   **MI**

Medical nutrition therapy for diabetes or renal disease (no recommended schedule)	Requires referral by treating physician for patient with diabetes or renal disease. Can be provided in same year as diabetes self-management training (DSMT), and CMS recommends medical nutrition therapy take place after DSMT. Up to 3 hours for initial year and 2 hours in subsequent years.			
Cardiovascular screening blood tests (every 5 years) • Total cholesterol • High-density lipoproteins • Triglycerides				
Diabetes screening tests (at least every 3 years, Medicare covers annually or at 6-month intervals for pre-diabetic patients) • Fasting blood sugar (FBS) or glucose tolerance test (GTT)	Patient must be diagnosed with one of the following: • Hyper tension • Dyslipidemia • Obesity (BMI >30 kg/m2) • Previous elevated impaired FBS or GTT … or any two of the following: • Over weight (BMI >25 but <30) • Family history y of diabetes • Age 65 years or older • History of gestational diabetes or birth of baby weighing more than 9 pounds			
Abdominal aortic aneurysm screening (once)	Patient must be referred through IPPE and not have had a screening for abdominal aortic aneurysm before under Medicare. Limited to patients who meet one of the following criteria: • Men who are 65-75 years old and have smoked more than 100 cigarettes in their lifetime • Anyone with a family history of abdominal aortic aneurysm • Anyone recommended for screening by the USPSTF			

Patient Name: _____ **DOB:** _____ **Chart #** _____

             Last,   **First**   **MI**

HIV screening (annually for increased risk patients) • HIV-1 and HIV-2 by EIA, ELISA, rapid antibody test or oral mucosa transudate	Patient must be at increased risk for HIV infection per USPSTF guidelines or pregnant. Tests covered annually for patients at increased risk. Pregnant patients may receive up to 3 tests during pregnancy.			
Smoking cessation counseling (up to 8 sessions per year) • Counseling greater than 3 and up to 10 minutes • Counseling greater than 10 minutes	Patients must be a smoker.			
Subsequent annual wellness visit	At least 12 months since last IPPE or AWV			
Other based on patient's risk factors:				
Other based on patient's risk factors:				
Other based on patient's risk factors:				

Provider's Signature: _____ Date: _____