CARE OF OLDER ADULT ASSESSMENT FORM (MEDICARE ONLY)

Date: ___ /___ /_____ Patient: _____ DOB:___ /___ /_____ ID#:_____

FUNCTIONAL ASSESSMENT CPT CAT II: 1170F

Cognitive Status: Excellent ____ Diminished ____ Dementia ____ Alzheimer's ____ Parkinson's ____ Other: _____

Ambulatory Status: Excellent ____ Good ____ Fair ____ Walks with Cane ____ Uses Wheelchair/Scooter____
Able to Climb Stairs ____ Needs Assistance ____ Amputation R____ L____ Prosthetic Devices: _____

Hearing: Excellent ____ Good ____ Fair ____ Poor ____ Deaf ____ Hearing Aids or Devices: _____

Vision: Excellent ____ Good ____ Fair ____ Poor ____ Uses Glasses ____ Uses Contacts ____ Cataract(s) ____
Glaucoma R ____ L ____ Macular Degeneration____ Blind ____

Speech: Excellent____ Good____ Fair____ Poor____

Other Functional Independence: (e.g., exercise, ability to perform job): _____

Smell/Taste: No Problem ____ Some Changes _____

Touch: Intact ____ Decreased Sensitivity (hot/cold) ____ Numbness____

IADLs Assessed: Y____ N____ **ADLs Assessed:** Y____ N____

Body Mass Index (BMI): _____

Physical Activity Monitoring/Counseling for Exercise: Y____ N____

Fall Risk Assessment: Y____ N____

Flu Vaccine: Y____ N____

Bladder Control Check: Y____ N____

Pneumococcal Vaccination: Y____ N____

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

PAIN ASSESSMENT CPT CAT. II: 1125F, 1126F

Pain: Y____ N____ **Date of Onset:** ___ /___ /_____ **Location (specify all sites):** _____

Frequency: Acute____ Chronic____ Intermittent____ Continuous____ Occasionally____

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

What Makes Pain Worse: Movement ____ Walking ____ Other: _____

What Makes Pain Better: Heat/Ice ____ Massage ____ Repositioning ____ Rest/Relaxation ____ Diversion ____
Other: _____

Treatment/Medication: _____

Member/Family Education Provided: Y____ N____ **Psychological Support:** Y____ N____

Under Pain Management: Y____ N____ **Dr.:** _____

Intensity:

Member:_____ ID #:_____ Today's Date:_____

ADVANCE CARE PLANNING CPT: 99497; CPTII: 1157F, 1158F; HCPCS: S0257

Advance Directive: Y____ N____ **Living Will:** Y____ N____

Surrogate Decision Letter: Y____ N____ **Actionable Medical Orders:** Y____ N____

★ **Date Discussed with member/family member** ___/___/_____ Copy of Document(s) in Chart?: Y____ N____

MEDICATION REVIEW

Administrative/Claims Data may be any of the following:

- **MEDICATION REVIEW CPT:** 90863, 99605, 99606 CPT CAT. II: 1160F ***AND*** **MEDICATION LIST** CPT CAT. II: 1159F, HCPCS: G8427

★ **Both review and list must be on the same date of service**

- **TRANSITIONAL CARE MANAGEMENT** (7 day) CPT: 99496
- **TRANSITIONAL CARE MANAGEMENT** (14 day) CPT: 99495

OR Medical Record Data:

Documentation must come from the same medical record and must include one of the following:

- A medication list in the medical record, and evidence of a medication review by a prescribing practitioner or clinical pharmacist and the date when it was performed.
- Notation that the member is not taking any medication and the date when it was noted.

A review of side effects for a single medication at the time of prescription alone is not sufficient.

Must submit both the Medication Review and Medication List together for same date of service.

Medication Review Completed: Y____ N____ Medication List Completed: Y____ N____ **See Medical Record for Medication List**

MEDICATION REVIEW – COA

Prescription and OTC Medications in Current Use Must document: Strength, Direction for use, Dose form, Quantity	Date of Initial Visit	Current Y/N	Prescribed by:
1.			
2.			
3.			
4.			
5.			
6.			
Please attach additional paper for all medications			

Provider Signature of Medication List Review Completed:_____ Date: _____

Provider Printed Name:_____

Provider Credentials: MD ____ DO ____ PA ____ ARNP ____

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