CARE OF OLDER ADULT ASSESSMENT FORM

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 ☐

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: _____

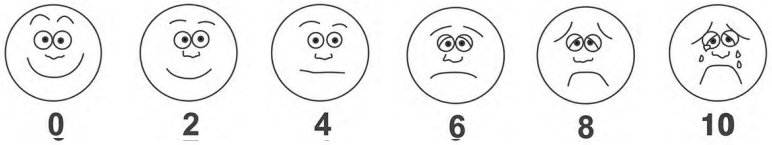
Member/Family Education Provided: Y ☐ N ☐ **Psychological Support:** Y ☐ N ☐

Under Pain Management: Y ☐ N ☐

Dr.: _____

Intensity:

Wong-Baker FACES® Pain Rating Scale



Physician Signature: _____

Physician Printed Name: _____

Comments: _____

_____

_____

Date: _____

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.			
7.			
8.			
9.			
10.			

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

Provider Printed Name:_____

Provider Credentials: MD ___ DO ___ PA ___ ARNP ___

Easy Choice HEALTH PLAN
A WellCare Company