CARE OF OLDER ADULT ASSESSMENT FORM (Medicare Only)

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

FUNCTIONAL ASSESSMENT CPT CAT II: 1170F

Cognitive Status:

Alert ____ Oriented ____ Dementia ____ Other:_____

Ambulatory Status:

Normal Gait____ Walks with Cane ____ Uses Wheelchair/ Scooter____ Needs Assistance ____ Amputation R____ L____

Hearing: (Must be assessed with vision and speech)

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

Vision: (Must be assessed with hearing and speech)

Good ____ Fair ____ Poor ____ Blind ____
Uses Contacts ____ Uses Glasses ____

Speech: (Must be assessed with hearing and vision)

Unimpaired____ Normal and Fluent____ Impaired____ Dyspraxia____ Aphasia____ Abnormal tongue/ lip movements____ Other_____

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

_____
_____
_____
_____

IADLs Assessed: Y__ N__	ADLs Assessed: Y__ N__
Instrumental Activities of Daily Living (Must assess at least 4)	Activities of Daily Living (Must assess at least 5)
(I= Independent, A=Assistance needed, D=Dependent)	
Meal Prep __ Shopping __ Housework __ Laundry __ Using Telephone __ Taking Medications __ Home Repair __ Finances __ Driving or Using Public Transportation __	Dressing __ Bathing __ Eating __ Transferring __ Use of Toilet __ Walking __

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

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

_____

Frequency:

Acute____ Chronic____ Continuous____ Intermittent____ 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

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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			

HEALTH MAINTENANCE

Body Mass Index (BMI): _____ Weight_____Bladder Control_____

Physical Activity Monitoring/Counseling for Exercise: Y____ N____ Fall Risk Assessment: Y____ N____

Flu Vaccine: Y____N____Pneumococcal Vaccination: Y____ N____ Colorectal: Y____ N____ Date: _____ Result: _____

Mammography: Y____ N____ Date: _____ Result: _____

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

Provider Printed Name:_____Provider Credentials: MD ____DO ____ PA ____ ARNP ____