Annual Care for Older Adults (COA) Form

Read Carefully

This form must be completed and signed by the provider. Please save a copy in the patient's medical records.

Patient Name: _____ **DOB:** _____ **ID #:** _____

Date Vitals Collected: _____ / _____ / _____ **Blood Pressure:** _____ / _____

Height: _____ **Weight:** _____ **BMI:** _____

Advance Care Planning (CPT II: 1123F, 1124F, 1157F, 1158F)	**Functional Status Assessment** (CPT II: 1170F)
Date discussed with Patient/Caregiver: _____ / _____ / _____ **Copy of Advance Care Plan in patient's chart:** ☐ **Yes** ☐ **No** Patient has: ☐ Advance Directives ☐ Surrogate Decision Maker ☐ Living Will ☐ Actionable Medical Orders	**Date Assessed:** _____ / _____ / _____ **Were patient's ADLs/iADLs assessed?** ☐ **Yes** ☐ **No** Check the most appropriate for ALL of the below: Cognitive Status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Ambulation Status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Hearing: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Vision: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Speech: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Pain Assessment (CPT II: 1125F, 1126F)

Date Assessed: _____ / _____ / _____ **Does the patient have pain?** ☐ **Yes** ☐ **No**

Medication List and Review (CPT II: 1159F, 1160F)

Attach the member's medication list OR document all prescriptions, over-the-counter and herbal supplements below.

Date: _____ / _____ / _____ **Medication List attached:** ☐ **Patient not taking any medications:** ☐

Medication/Dosage/Frequency	**Medication/Dosage/Frequency**

Provider Name (Print): _____

Credentials: ☐ **MD** ☐ **DO** ☐ **NP** ☐ **PA** ☐ **PharmD** ☐ **Other:** _____

Provider Signature: _____ **Date:** _____ / _____ / _____

If the form is filled out by an office or clinical support staff member, it must route back to the provider for follow-up and sign off.

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