Patient FACTS

Medicare Annual Wellness Visit

Please review the below columns to see what is included/not included during your visit.

Included in your annual wellness visit	NOT included in your annual wellness visit
Check of height, weight, blood pressure	Physical exam
Health risk assessment	Illness diagnosis
A review of your health and family history	Diagnostic tests like x-rays, ultrasounds, and bloodwork
Sharing a list of the health care professionals you see	Treatments for any condition you may have
Sharing a list of any medical equipment you use and where you get it	Refills on existing problems
A review of all of the medicines, supplements, and vitamins you are currently taking	
Testing for depression and mental health problems	
Talking about risks for certain health problems and personal health advice	
Planning a schedule of screening tests and shots you should receive over the next 5-10 years	
Referrals to any preventive services you may need	

If time allows the Provider will discuss any concerns NOT included in your Medicare Annual Wellness Visit, however, please be aware that this is then billed as a separate office visit code, which, depending on your plan may incur a copay.

Pharmacy: ______________________________ Lab: ______________________________

KATZ ADL

Bathing

- Independent: Bathes self completely or needs help in bathing only a single part of the body, such as the back, genital area, or disabled extremity
- Dependence: Needs help with bathing more than one part of the body, getting in or out of the tub or shower. Requires total bathing.

Dressing

- Independent: Gets clothes from closet and drawers and puts on clothes and outer garments complete with fasteners. May have helped tying shoes.
- Dependence: Needs help with dressing self or needs to be completely dressed.

Toileting

- Independence: Goes to toilet, gets on and off, arranges clothes, cleans genital area without help.
- Dependence: Needs help transferring to the toilet and cleaning self or uses bedpan or commode

Transferring

- Independence: moves in and out of bed or chair unassisted. Mechanical transferring aides are acceptable.
- Dependence: Needs help in moving from bed to chair or requires a complete transfer

Continence

- Independence: Exercises complete self-control over urination and defecation.
- Dependence: Is partially or totally incontinent of bowel or bladder

Feeding

- Independence: Gets food from plate into mouth without help. Preparation of food may be done by another person.
- Dependence: Needs partial or total help with feeding or requires parenteral feeding.

STEADI Fall Risk

- Have you fallen in the past year?
  - Yes No
- Do you use or have you been advised to use a cane or walker to get around safely?
  - Yes No
- Do you sometimes feel unsteady while walking?
  - Yes No
- Do you steady yourself by holding onto furniture when walking at home?
  - Yes No
- Do you worry about falling?
  - Yes No
- Do you need to push with your hands to stand up from a chair?
  - Yes No

Cont. STEADI Fall Risk

- Do you have trouble stepping up onto a curb?
    - Yes No
- Do you often have to rush to the toilet?
    - Yes No
- Have you lost some feeling in your feet?
    - Yes No
- Do you take medicine that sometimes makes you light-headed or more tired than usual?
    - Yes No
- Do you take medicine to help you sleep or improve your mood?
    - Yes No
- Do you often feel sad or depressed?
    - Yes No

Falls Efficacy Scale

Take a bath or shower

1=very confident 2 3 4 5 6 7 8 9 10=not confident at all

Reach into cabinets or closets

1=very confident 2 3 4 5 6 7 8 9 10=not confident at all

Walk around the house

1=very confident 2 3 4 5 6 7 8 9 10=not confident at all

Prepare Meals not requiring carrying heavy or hot objects

1=very confident 2 3 4 5 6 7 8 9 10=not confident at all

Get in and out of bed

1=very confident 2 3 4 5 6 7 8 9 10=not confident at all

Answer the door or telephone

1=very confident 2 3 4 5 6 7 8 9 10=not confident at all

Getting dressed or undressed

1=very confident 2 3 4 5 6 7 8 9 10=not confident at all

Personal grooming (i.e., washing your face, brushing teeth, combing hair)

1=very confident 2 3 4 5 6 7 8 9 10=not confident at all

Getting on and off the toilet

1=very confident 2 3 4 5 6 7 8 9 10=not confident at all

PATIENT HEALTH QUESTIONNAIRE-9
(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + ______ + ______ + ______

______ =Total Score: ______

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

CAGE Test

Have you ever felt you should **Cut** down on your drinking?	Yes / No
Have people **Annoyed** you by criticising your drinking?	Yes / No
Have you ever felt bad or **Guilty** about your drinking?	Yes / No
Have you ever had a drink first think in the morning to steady your nerves or get rid of a hangover (**Eye-opener**)?	Yes / No