Packet for Medicare's Wellness Visits

As many of you are aware Medicare now offers an Annual Wellness Visit as a benefit for all Medicare patients. While we are pleased that more seniors will have access to basic preventive services and counseling, we also want you to understand that this "Wellness Visit" **is not the same as a physical exam**.

In the recent healthcare bill "The Affordable Care Act of 2010," the government mandates the requirements for this new annual wellness visit. In general, the aim of this visit is to review a patient's history, screen for common problems such as hearing loss and dementia, recommend age appropriate health screening, and counsel a patient regarding wellness and prevention. The only "physical" elements in this visit include basic vital signs and the performance of biannual breast/pelvic/pap smears in women and annual prostate exams in men. So for those of you who are used to getting annual physicals, this visit will be a very different experience.

Please understand that because of the strict guidelines regarding these visits and the time constraints with all the information that must be reviewed, your physician will not be able to address other issues on the day of your wellness visit. You will need a separate appointment to take care of new issues or issues related to management of chronic medical problems. Also, as a result of screening your physician may identify areas in which further evaluation is needed. For example if the annual wellness visit reveals an area of concern, then we will ask that you return for a separate visit to fully assess the degree of that problem and discuss treatment options with you at that later time.

Enclosed you will find several forms. Please fill them out completely to ensure that you get the most out of your visit and to help us to comply with all Medicare requirements. Also if you have had immunizations elsewhere please bring a record of all immunizations with you to your visit.

Thank you for your cooperation and we hope this visit's focus on prevention will be a valuable service to you.

Patient Name:_____ Date of Birth:_____ Date of Service:_____

Please list below the other physicians and specialists you see:

Name: _____Phone:_____ Specialty: _____

Name: _____Phone:_____ Specialty: _____

Name: _____Phone:_____ Specialty: _____

Name: _____Phone:_____ Specialty: _____

Name: _____Phone:_____ Specialty: _____

Name: _____Phone:_____ Specialty: _____

Name: _____Phone:_____ Specialty: _____

Name: _____Phone:_____ Specialty: _____

Name: _____Phone:_____ Specialty: _____

Name: _____Phone:_____ Specialty: _____

Name: _____Phone:_____ Specialty: _____

Name: _____Phone:_____ Specialty: _____

Name: _____Phone:_____ Specialty: _____

Please list below the medical support companies you use. Include pharmacies (local and mail order), durable medical supply company, home care agency, oxygen supply company, etc.

Company Name: _____Purpose/provides: _____

Company Name: _____Purpose/provides: _____

Company Name: _____Purpose/provides: _____

Company Name: _____Purpose/provides: _____

Company Name: _____Purpose/provides: _____

Company Name: _____Purpose/provides: _____

Patient Name:_____ Date of Birth:_____ Date of Service:_____

Please list all medications, supplements and over the counter medications:
Medication Name, Dose, # Tablets, and Frequency

Medication Name	**Dose**	**# Tablets**	**Frequency**

Patient Name:_____ Date of Birth:_____ Date of Service:_____

Self Health Risk Assessment

Hearing Screen

Yes/No Do people complain that you turn the TV volume too high?

Yes/No Do you find yourself asking people to repeat themselves?

Yes/No Do you have trouble hearing in a noisy background?

Yes/No Do you or your family members think you have difficulty hearing?

Depression Screen

Yes/No Over the past two weeks, have you felt down, depressed or hopeless?

Yes/No Over the past two weeks, have you felt little interest or pleasure in doing things?

Cognitive Screen

Yes/No Do you, your family members, or close friends have concerns about your memory or general mental functioning?

Nutrition Screen

Yes/No Do you eat least 2 servings of vegetables daily?

Yes/No Do you eat at least 2 servings of fruit daily?

Yes/No Do you avoid fried foods like fries and potato chips?

Yes/No Do you avoid non-diet soda/fruit drinks and limit sweets?

Yes/No Do you eat at least 2 servings of whole grain products daily?

Yes/No Do you eat at least 8 ounces of meat or protein daily?
(3 ounces of meat = size of deck of cards)

Yes/No Do take a calcium supplement?

Yes/No Do take a vitamin D supplement?

Patient Name:_____ Date of Birth:_____ Date of Service:_____

Self Health Risk Assessment (continued)

Functional Ability Screen

Do you need any help with the following?

Yes/No Bathing

Yes/No Dressing

Yes/No Walking

Yes/No Shopping

Yes/No Housekeeping

Yes/No Managing Medications

Yes/No Managing Finances

Yes/No Meal Preparation

Yes/No Transportation

Urinary Leakage

Yes/No Have you experienced any urinary incontinence (leakage) in the last 6 months?

Yes/No If so, has it changed your daily activities or interfered a lot with sleeping?

Yes/No Have you discussed this problem with your health care provider?

Fall Screen

How many times have you fallen in the last 12 months? _____ zero _____one _____ two or more

Did any fall result in a major injury? _____ yes _____ no

Do you have any of the following potential fall risks in your home?

_____ throw rugs

_____ slippery tub or absence of grab bars in the bathroom

_____ dim lighting

_____ stairs

Patient Name:_____ Date of Birth:_____ Date of Service:_____

Advance Care Planning

Advance Directives are legal documents that allow you to put in writing what kind of health care you would want if you were too ill to make decisions for yourself. Specifically, a Medical Durable Power of Attorney allows you to name someone to make decisions about your medical care if you can no longer speak for yourself. Another document called a Living Will (in Colorado this is sometimes called the Colorado Declaration) allows you to state your wishes about medical care in the event you develop a terminal condition or are in a persistent vegetative state. If you do already have these documents, it is important that you bring a copy for your chart.

Yes/No Do you have a Medical Power of Attorney? If so, please bring a copy of this document with you for us to have on file.

Yes/No Do you have a Living Will?

Yes/No For those who have completed paperwork for Advance Directives, have you expressed that you wish to be a DNR (Do Not Resuscitate)?

Yes/No For those who have not completed Advance Directives would you like further information on how to do so?