MetroPlus Health Plan

# CARE FOR OLDER ADULTS ASSESSMENT FORM

Date of Patient Assessment: ___/___/___ Patient Name: _____ DOB: ___/___/___

Weight: _____ Height: ____ BMI: _____ **BMI ICD-10: Z68.1, Z68.2-Z68.39, Z68.41-Z68.45**

## FUNCTIONAL STATUS ASSESSMENT

**CPT: 1170**

### General Assessment

Falls or problems with balance: ☐ Yes ☐ No

Started or planning to exercise: ☐ Yes ☐ No

Flu shot in 2018: ☐ Yes ☐ No

Mammogram in the past 5 Years: ☐ Yes ☐ No

Colon Cancer Screening: ☐ Yes ☐ No

### Activities of Daily Living

Can the member perform all activities of daily living (ADL) independently?
☐ Yes ☐ No If No, the member needs help with:
☐ Bathing ☐ Dressing ☐ Eating ☐ Transferring ☐ Toileting ☐ Walking

Can the member perform all instrumental ADL's (IADL) independently?
☐ Yes ☐ No If No, the member needs help with:

| | | |
|---|---|---|
| ☐ Shopping | ☐ Transportation | ☐ Using the phone |
| ☐ Meal preparation | ☐ Housework | ☐ Home repair |
| ☐ Laundry | ☐ Taking Medications | ☐ Handling Finances |

## ADVANCE CARE PLANNING

**CPT: 99497, 1123F, 1124F, 1157F, 1158F HCPCS: S0257**

Discussed Advance Directives with Member? ☐ Yes ☐ No If member has advance directives, list: _____

## MEDICATION REVIEW

**MEDICATION REVIEW CPT: 90863, 99605 99606, 1160F AND MEDICATION LIST CPT: 1159F HCPCS G8427**

Member on Medication(s): ☐ Y ☐ N Reviewing Practitioner Name/Signature: _____ Review Date: _____

| Medication | Dose/Frequency | Medication | Dose/Frequency |
|---|---|---|---|
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## PAIN ASSESSMENT

**CPT: 1125F, 1126F**

Do you have pain? ☐ Yes ☐ No
If yes, circle the severity:

☺ — 😐 — ☹

**0-1-2-3-4-5-6-7-8-9-10**

If yes, date of onset: _____
If yes, location of pain: _____

MetroPlus will share this Annual Wellness Assessment form with your provider

*****Please scan form into EMR System or file in medical record*****