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# Annual Wellness Assessment

**Patient Full Name:** _____ **DOB**: _____/_____/_____ **Gender:** Male / Female / Other
(Date of Birth; Circle one)

**Member ID#:**_____ **Health Plan**:_____ **Allergy**:_____ **Date:** ____/____/_____
(Patient Identifier; Date of Service)

| **Vital Signs** | **BP:____/____** | **HR: _____Ht: _____ft. _____in. _____ Wt (lbs.) _____ BMI: _____** |
|---|---|---|

IHA/AHA CPT Codes: □ G0402 Initial physical, New patient □ G0438 Annual wellness visit, First visit □ G0439 Annual wellness visit, Subsequent visit

**Procedure Code □ 3008F** **Check the Appropriate "BMI" Code below:**

__BMI < 19 (Z68.10); __BMI 20.0-20.9 (Z68.20);__BMI 21.0-21.9 (Z68.21);__BMI 22.0-22.9 (Z68.22); Wheelchair Dependent __ (Z99.3)

__BMI 23.0-23.9 (Z68.23); __BMI 24.0-24.9 (Z68.24); __BMI 25.0-25.9 (Z68.25); __BMI 26.0-26.9 (Z68.26); __BMI 27.0-27.9 (Z68.27);

__BMI 28.0-28.9 (Z68.28); __BMI 29.0-29.9 (Z68.29); __BMI 29.0-29.9 (Z68.29);__BMI 30.0-30.9 (Z68.30); __BMI 31.0-31.9 (Z68.31);__BMI 32.0-32.9 (Z68.32)

__BMI 33.0-33.9 (Z68.33); __BMI 34.0-34.9 (Z68.34); __BMI 35.0-35.9 (Z68.35);__BMI 36.0-36.9 (Z68.36); __BMI 37.0-37.9 (Z68.37); __BMI 38.0-38.9 (Z68.38)

__BMI 39.0-39.9 (Z68.39); __BMI 40.0-40.9 (Z68.41); __BMI 45.0-45.9 (Z68.42); __BMI 50.0-50.9 (Z68.43); __BMI 60.0-69.0 (Z68.44); __BMI 70 or greater (Z68.45)

**Check the Appropriate "Blood Pressure" Procedures (SBP =Systolic BP; DBP =Diastolic BP):**

__SBP < 130 (3074F); __SBP 130-139 (3075F); __SBP 140 or over (3077F); __DBP < 80 (3078F); __DBP 80-89 (3079F); __DBP 90 or over (3080F)

**History of Present Illness:**_____ **(reason for visit)**

**Review of systems**

**Past Medical, Family and Social History**

**Physical Exam (Please complete thoroughly each section unless exam component was deferred)**

| **If deferred, check here □** | | **Normal** | **Abnormal** | **Describe Finding** |
|---|---|---|---|---|
| □ | GENERAL | | | |
| □ | HEAD | | | |
| □ | EYES | | | |
| □ | ENT | | | |
| □ | NECK | | | |
| □ | RESP | | | |
| □ | CV | | | |
| □ | CHEST / BREAST | | | |
| □ | GI | | | |
| □ | LYMPH | | | |
| □ | MS | | | |
| □ | SKIN | | | |
| □ | PSYCH | | | |
| □ | NEURO | Alert/Oriented to: □ Person □ Place □ Time □ Situation | | |

| | |
|---|---|
| OTHER LAB RESULTS (state specific findings & add diagnosis to assessment/plan) | |
| OTHER XRAY RESULTS (state specific findings & add diagnosis to assessment/plan) | |

| SCREENING | RESULTS | DATE OF SCREENING | NEXT SCREENING | CPT 2 CODES |
|---|---|---|---|---|
| **Breast Cancer Screening** (every 2 yrs., ages50-74) | Mammogram: Findings: | | | 77055 unilateral, 77056 bilateral, 77057 bilateral (2 views of each breast)<br>G0202 bilateral (2view study of each breast including CAD;<br>G0204 bilateral study including CAD;<br>G0206 unilateral study including CAD<br>77063 Sreening digital tomosynthesis (bilateral)<br>G0279 Diagnostic digital breast tomosynthesis, unilateral or bilateral (list separately in addition to G0204 or G0206) |
| **Cervical Cancer Screening** (every 3 yrs., ages 21-64) | Lab Result: Findings: | | | Cervical Cytology: 88141-88143<br>HPV Test: 87620-87622 |
| **Colon Cancer Screening** FOBT or FIT test annually, Sigmoidoscopy every 5yrs, Colonoscopy x10 yrs; ages 50-75 | Colonoscopy Results: | | | FOBT: 82270, 82274<br>FIT: 82274<br>Flexible Sigmoidoscopy: 45330-45335<br>Colonoscopy: 45378 |
| **Diabetes Nephropathy** Urine Microalbumin Screening (annually) | Results:<br>Positive □<br>Negative □ | | | (+) 3060F<br>(-) 3061F |
| **Diabetes: A1c screening** (annually) | Lab Results (e.g. 7.3%): _____ | | | (<7%): 3044F,<br>(7-9%): 3045F,<br>(>9.0%): 3046F |
| **Lipid Panel Test** (annually)<br>**LDL-C<100MH/DL**<br>**LDL-C 100-129MG/DL**<br>**LCL-C<130MG/DL** | Lab Result: | | | 3011F<br>3048F<br>3049F<br>3050F |

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**Patient Full Name:** _____ **DOB**: _____/_____/_____ **Date:** ____/____/_____
Date of Birth Date of Service

**PATIENT EDUCATION:**

___Fall Prevention ___Asthma ___Breast Self-Exam ___Cholesterol ___Diabetes ___Testicular Self-Exam ___Tobacco Cessation ___Tuberculosis ___Obesity
___Diet ___Exercise ___Family Planning ___Hypertension ___Immunizations ___Medications ___Medication Adherence ___STD's ___Substance Abuse ___Other

**Preventive Care (Medicare STARs/HEDIS)**

| | | | |
|---|---|---|---|
| Functional Status Assessment | Activities of Daily Living | Z00.0 | □ **(1170F)** ADL's<br>Grooming: □ Independent □ Assistance Needed □ Dependent<br>Dressing: □ Independent □ Assistance Needed □ Dependent<br>Bathing: □ Independent □ Assistance Needed □ Dependent<br>Toileting: □ Independent □ Assistance Needed □ Dependent<br>Walking: □ Independent □ Assistance Needed □ Dependent<br>Eating: □ Independent □ Assistance Needed □ Dependent<br>Transferring: □ Independent □ Assistance Needed □ Dependent |
| Advance Care Planning | • Discussed advance directive with patient<br>□ Patient refused | Z00.0 | □ **(1157F)** Advanced Care Plan or other legal document present in medical record<br>□ (**1158F**) Advanced Care Plan discussion documented in medical record |
| Bladder Control Screening | □ Continence<br>□ Incontinence | Z00.0 | □ **(1090F)** Assessed |
| Fall Risk Screening | • Fall prevention discussed<br>Number of falls this year: | Z00.0 | □ **(3288F)** Assessed<br>□ **(1100F)** 2+falls<br>□ (**1101F)** 0-1 falls |
| Physical Activity Screening | □ Exercise counseling<br>□ Increase physical activity<br>□ Maintain physical activity | Z71.89 | □ **(4245F)** Assessed |
| Tobacco Cessation<br>All active tobacco users only | □ Smoker<br>□ Non-smoker<br>□ Smoking cessation counseling | F17.200 | □ **(4004F)** Cessation counseling |
| Pain Assessment/Screening | • No-pain present<br>• Pain present<br>Levels 1-10):<br>_____<br>• Pain management plan | Z00.0 | □ **(1126F)** if 0 pain level noted<br>□ (**1125F)** if 1-10 level pain noted; □ (**0521F)** Plan of care to address pain documented |

**Check both the "Medication List" and "Medication Review" Codes: □ Medication List ( 1159F ); □ Medication Review ( 1160F )**

**List of Medications for Medication Review (Name of Medicine, Quantity and Dosage Level):**

| Name of Medicine | Dosage Level | Quantity | Comment |
|---|---|---|---|
| | | | |
| | | | |
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# Annual Wellness Assessment

**Patient Full Name:** _____ **DOB**: _____/_____/_____ **Date:** ____/____/_____
Date of Birth Date of Service

**Depression Screening (PHQ9) Code: □ G0444**

| **Over the last 14 days, how often have you been bothered by any of the following problems?** | **□ 0** | **□ 1 to 6** | **□ 7 to 11** | **□ 12+** |
|---|---|---|---|---|
| Little interest or pleasure in doing things | □ 0 | □1 | □2 | □3 |
| Feeling down, Depressed or hopeless | □ 0 | □1 | □2 | □3 |
| Trouble falling asleep, staying asleep, or sleeping too much | □ 0 | □1 | □2 | □3 |
| Feeling tired or having little energy | □ 0 | □1 | □2 | □3 |
| Poor appetite or overeating | □ 0 | □1 | □2 | □3 |
| Trouble concentrating on such things as reading the newspaper or watching TV | □ 0 | □1 | □2 | □3 |
| Feeling bad about yourself, feeling that you are a failure, feeling that you have let yourself or your family down | □ 0 | □1 | □2 | □3 |
| 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 |
| Thinking that you would be better off dead or that you want to hurt yourself in some way | □ 0 | □1 | □2 | □3 |

| **Diagnosis Guide** | Total score: Depression Severity:<br>1-4 Minimal Depression<br>5-9 Mild Depression<br>10-14 Moderate depression<br>15-19 Moderately severe depression - Refer to Case Management<br>20-27 Severe depression - Refer to Case Management | **Total score:** |
|---|---|---|

Unable to complete the depression assessment due to: □ Unresponsive □ Uncooperative □ Severe Dementia □ Patient Refused □ Other (explain below)

**On Treatment for Depression?** Yes □ No □

Additional Notes / Comments:

**Physicians to complete:**

| DIAGNOSIS DESCRIPTION | STATUS OF DIAGNOSIS | PLAN OF CARE / CURRENT RX |
|---|---|---|
| | □ Stable □ Condition worsening □ Condition improving | |
| | □ Stable □ Condition worsening □ Condition improving | |
| | □ Stable □ Condition worsening □ Condition improving | |
| | □ Stable □ Condition worsening □ Condition improving | |
| | □ Stable □ Condition worsening □ Condition improving | |
| | □ Stable □ Condition worsening □ Condition improving | |
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| | □ Stable □ Condition worsening □ Condition improving | |
| | □ Stable □ Condition worsening □ Condition improving | |
| | □ Stable □ Condition worsening □ Condition improving | |

**I have reviewed this visit with the member and I hereby verify all of the above is correct.**

**Provider's Name (Print):** _____ **Provider's Signature:** _____

**Date:**_____ **Provider Credential (e.g., MD, DO, NP, PA):**_____