CARE OF OLDER ADULTS ASSESSMENT FORM

Date of Patient Assessment: ___/______/______Patient Name:___________________________________DOB:___/____/________

Member ID#___________________________ Physician Name: ________________________________

Weight: ______________ Height: _______________ BMI Value (calculated): ____________

FUNCTIONAL ASSESSMENT (Circle those that apply in the Overall Assessment and include any additional details about the status)

	Overall Assessment				Additional Details
Cognitive Status:	Excellent	Good	Fair	Poor	Dementia Alzheimer's Parkinson Other: ________________
Ambulation Status:	Excellent	Good	Fair	Poor	Walks with Cane Needs Assistance Able to Climb Stairs Amputation R/L-AKA Prosthetics Devices Other:___________
Speech:	Excellent	Good	Fair	Poor	Mute Other: ________________
Hearing:	Excellent	Good	Fair	Poor	Deaf Use of Hearing aids/ Device
Vision:	Excellent	Good	Fair	Poor	Uses glasses/contacts Cataract(s) Glaucoma Blind Macular Degeneration DM Retinopathy Other:________________
Touch:	Excellent	Good	Fair	Poor	Decreased sensitivity (Hot/ cold) numbness
Smell/ Taste:	Excellent	Good	Fair	Poor	Decreased sensitivity Other: ____________________________

Can the patient perform all activities of daily living (ADL) independently (Y) _____ (N) ____
If NO, Circle any activities of daily living (ADL) the patient requires assistance with:

Dressing Bathing Eating Transferring (e.g. getting in and out of chairs) Toilet Use Walking other:__________________

MEDICATION REVIEW LIST (Complete the Medication Review by Indicate with a "X" for YES (Y) and NO (N))

Member on Medication: (Y) ___ (N) ___ **Date performed**: ___/____/____ **Reviewing Practitioner name:** _____________________________________
Medication Review (review of all a member's medications, including medication names only or may include medication names, dosages and frequency, over-the-counter (OTC) medications and herbal or supplemental therapies by a prescribing practitioner or clinical pharmacist and the date when it was performed.)

Medication	Dose/Frequency	Medication	Dose/Frequency

Reminder: *Both Medications review and Medication list must be submitted together for the same date of service*

PAIN ASSESSMENT (Complete the Pain Assessment by completing the form below)

Under Pain Management Plan: (Y) ____ (N) ____ Under Pain Treatment: (Y)____ (N)____
Reminder: Notation of a pain management plan alone, notation of a pain treatment alone, notation of screening for chest pain alone or documentation of chest pain alone does not meet criteria

	Y/N	Level of Pain (1-5)	Date of Assessment	Comments/Additional information
Overall (Any pain?)				
Head/Neck				
Torso				
Other _____________				

ReviPractitioner's Signature: ______________________________________
Comments: ____

CPT II IDENTIFICATION CODES: **Functional Status Assessment CPT II: 1170F; Advance Care Planning: CPT II & HCPCS: 1157F, 1158F, S0257;**
Pain Assessment: CPT II 1125F, 1126F; Medication Review CPT II & HCPCS: 90863, 99605, 99606, 1160F; Medication List: CPT II & HCPCS: 1159F, G8427