Optimum
Internal Medicine & Pediatrics

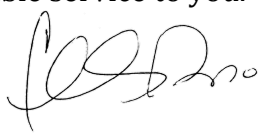
Packet for Medicare's Wellness Visits

Medicare covers an Annual Wellness Visit after you have had Part B for more than 12 months, provided you have not had a Welcome to Medicare preventive visit or an Annual Wellness Visit within the past 12 months. This prevention visit is not a routine physical examination.

Your wellness visit focuses on prevention. Please schedule a separate appointment for new concerns or ongoing medical problems. Screening may identify issues that need a separate evaluation and treatment visit.
If additional problems, tests, or services are addressed during the same visit, they may be billed separately. Coinsurance, copayments, or deductibles may apply depending on the service and your coverage; noncovered services may cost more. Check your Medicare Advantage plan for its benefits and costs. The covered Annual Wellness Visit itself has no Part B deductible or coinsurance when the provider accepts assignment.

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.



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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: _____

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.

Preferred Pharmacy Name/Location: _____

Secondary Pharmacy Name/Location:_____

Mail Order Pharmacy Name/Location:_____

Should all your routine medicines go to your Preferred Pharmacy or a Mail Order Pharmacy (Circle)? Preferred Pharmacy or Mail Order Pharmacy

Company Name: _____Purpose/provides: _____

Company Name: _____Purpose/provides: _____

Company Name: _____Purpose/provides: _____

Company Name: _____Purpose/provides: _____

Company Name: _____Purpose/provides: _____

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

Please list all medications, supplements and over the counter medications:

Medication name, strength, amount per dose, and frequency

Medication name	Strength	Amount per dose	How often / route

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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?

Protein foods you usually eat: _____
Discuss a protein goal with your clinician based on your health and nutrition needs.

Yes/No Do take a calcium supplement?

Yes/No Do take a vitamin D supplement?

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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

Tennessee's Advance Directive for Health Care combines treatment instructions and health care agent appointment. Follow the form's "When Effective" choice: you may allow your agent to act at any time, or only when you no longer have capacity. Bring existing directives, health care powers of attorney, living wills and DNR/POST orders. Ask staff for the official Tennessee form if needed. This page records history only. It does not create or change an advance directive or medical order.

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?