Optimum
Internal Medicine & Pediatrics

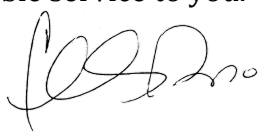
Packet for Medicare's Wellness Visits

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**.

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, Dose, # Tablets, and Frequency

Medication Name	**Dose**	**# Tablets**	**Frequency**
ex. Aspirin	*81 mg*	*90 tablets*	*1 tablet by mouth daily*

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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?

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

Tennessee's Advance Directive for Health Care lets you record your treatment wishes and name a health care agent to speak for you when you cannot make or communicate your decisions. The state's model form combines health care agent appointment and advance-care instructions in one document.
Bring copies of any existing advance directive, health care power of attorney, living will, or DNR/POST order for your chart. Ask staff for Tennessee's official form if needed.
This page records your history only; it does not create an advance directive or a DNR order. Your answers below do not change an existing document 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?