Aspen Medical Group

Crista Keller, M.D.
Megan Press, M.D.
Katherine Johnson, NP-C
Susan Esmond, PA-C
E. Kendrick Lane, PA-C

To our valued Medicare Patients,

Medicare will now be covering a free annual wellness visit. This is a ***new*** benefit for our senior patients. The Annual Wellness Visit is different from a traditional routine physical because it screens for risks specific to the senior population (such as fall prevention).

Your annual wellness visit is the ***only*** preventative visit that Medicare will reimburse. We ask, therefore, that this visit be limited to developing your personalized prevention plan – a written list of tests and interventions that your provider recommends specifically for you.

If you do have a more urgent concern (such as chest pain, problems urinating, joint pain, etc.), we request that you schedule a separate appointment to address this. Copays and deductibles will apply for any care that is not part of the Annual Wellness Visit.

To make your Annual Wellness Visit as helpful as possible, we ask that you do the following:

- Compete the attached Annual Wellness Visit form ***before*** your appointment and make sure to bring it with you. Your visit may need to be rescheduled if you do not have your completed form with you.

- Bring documentations of any vaccinations you have received

- Bring in copies of any advanced directives or medical durable power of attorney forms.

- Please arrive 15-30 minutes early to allow our medical assistants time to check your vital signs, vision and hearing.

We look forward to seeing you soon for your Annual Wellness Visit! Please call us with any questions or concerns at 303-394-9355.

Sincerely,

The Providers and Staff of Aspen Medical Group

Medicare Wellness Visit

Patient Questionnaire

Provider Initials	Date

Name: _____

Today's Date: _____/_____/_____ Date of Birth: _____/_____/_____

Gender: Male Female Race (circle): Caucasian African American Latino Other:_____

Past Medical History: Please list all major medical problems (i.e. high blood pressure, high cholesterol, diabetes, heart disease, asthma, sleep apnea, etc.):_____

_____

_____

_____

_____

Current List of Specialists You See:

Name	Specialty	Reason

Please list any surgeries you have had including dates:

_____

_____

_____

List medications and dose you are on: (circle) ☐See attached list

Medication:	Dose:	Frequency:	Medication:	Dose:	Medication:	Dose:

Drug Allergies: _____

Have you ever used Tobacco? (circle) No Yes Quit
If yes, what type (circle) Cigarettes Chew Pipe Cigar _____packs per day for the last _____years
Alcohol use? ____drinks per ☐day ☐week ☐month
Recreational drug use? (circle) No Yes Type(s): _____
What is your (current/former) occupation? _____
Who lives with you at home? _____
Do you exercise? No Yes If yes, _____times per week Type:_____
Are you on a special diet? No Yes If yes, why?_____
Do you always fasten your seat belt? No Yes Do you wear sunscreen? No Yes
Do you have any problems performing dressing, feeding, toileting, or grooming? No Yes
Do you need help with shopping, food preparation, housekeeping, taking medicine or managing finances? No Yes

Patient Name _____ **DOB** _____

Have any of your family members had the following health problems?

Check ALL that apply and state WHO in your family had each problem.

- ☐ None
- ☐ **Heart Disease** _____
- ☐ **High Blood Pressure** _____
- ☐ **Diabetes** _____
- ☐ **Asthma** _____
- ☐ **Thyroid Problems** _____
- ☐ **Stroke** _____
- ☐ **Bleeding Disorder** _____
- ☐ **Osteoporosis** _____
- ☐ **Cancer, Type** _____

Have you had any of the following in the last 2 weeks? Check all that apply.

☐ **I have not had any of these problems**

Constitutional

- ☐ Recent weight change
- ☐ Fever
- ☐ Weakness
- ☐ Fatigue
- ☐ Other _____

Gastrointestinal

- ☐ Heartburn
- ☐ Nausea/vomiting
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Other _____

Endocrine

- ☐ Hot flashes
- ☐ Excessive thirst
- ☐ Heat/cold intolerance
- ☐ Other_____

HEENT

- ☐ Visual problems
- ☐ Hearing Problems
- ☐ Dry mouth
- ☐ Snoring
- ☐ Other_____

Musculoskeletal

- ☐ Severe muscle pain
- ☐ Severe joint pain
- ☐ Other_____

Hematological

- ☐ Easy bruising
- ☐ Other_____

Cardiovascular

- ☐ Chest pain
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Other_____

Neurological

- ☐ Severe headache
- ☐ Numbness
- ☐ Tingling
- ☐ Other _____

Immunologic

- ☐ Swollen lymph nodes
- ☐ Other _____

Respiratory

- ☐ Chronic cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Oxygen use
- ☐ Other_____

Skin

- ☐ Rashes
- ☐ New/changing moles
- ☐ Sores
- ☐ Lumps
- ☐ Other_____

Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ Other_____

Do you have an Advanced Directive (Circle): Yes No

Advanced Care Planning Consent: I consent to discuss end-of-life planning issues with my healthcare provider. **(Circle): Yes No**

_____ _____

Patient/Guardian Signature Date

Patient Name _____ DOB _____

Medicare Annual Wellness Visit

***** TO BE COMPLETED BY MEDICAL ASSISTANT *****

Patient's Name: _____

Date of Exam: _____/_____/_____ Date of Birth: _____/_____/_____

Medical History (□See AWV Pt Questionnaire Dated _____/_____/_____)

Medications: (□See List)

Family History (List positive results from AWV Questionnaire) *See Flow Sheet*

Exam:
Height:
Weight
BMI:
BP:
HR:
SPO2:
Visual Acuity: L 20/ R 20/
Whisper Test: Pass Fail

Depression Screen (ask the following questions, circle the response)

1. Over the last two weeks, have you felt down, depressed or hopeless? No Yes
2. Over the last two weeks, have you felt little interest or pleasure in doing things? No Yes

Hearing Loss Screen

1. Do you have trouble hearing the television or radio when others do not? No Yes
2. Do you have to strain or struggle to hear/understand conversations? No Yes

Function Screen

1. Do you need help with preparing meals, transportation, shopping, taking you medicine, managing your finances, or other activities of daily living? No Yes
2. Do you live alone? No Yes

Home Safety Screen

1. Does your home have throw rugs, poor lighting, or a slippery bathtub/shower? No Yes
2. Does your home LACK grab bars in bathrooms, handrails on stairs and steps? No Yes
3. Does your home LACK functioning smoke alarms? No Yes

Risk for falls Screen

1. Was the patient unsteady or take longer than 30 seconds during the timed "get up and go" test? No Yes

Detection of Cognitive Impairment: No Yes Notes :_____

Advanced Care Planning

1. Patient already has executed and Advance Directive? No Yes
2. If no, patient was given an opportunity to execute and Advance Directive today? No Yes
3. Physician statement "This individual has the ability to prepare an Advance Directive." No Yes
4. Physician has completed a physician order for life-sustaining treatment, or similar document of reflecting the patient's wishes for an advanced care plan. No Yes
5. Physician is willing to follow the patient's wishes. No Yes

_____ _____

Physician Signature **Date**

Patient Name _____ **DOB** _____

ASSESSMENT AND PLAN:

1. **Annual wellness visit V70.0. Pt given written copy of recommended preventive measures below. F/u appt recommended in:**

Physician Signature _____ Date_____

Preventive screen (frequency)	Coverage	Previously tested (If yes, when?)	Scheduled for screenings (5 to 10 years)
Bone Mass Measurements (every 24 months)	Medicare patients at risk for developing Osteoporosis		
Cardiovascular Screening Blood Tests (every 5 years) – **Lipid panel** – **Cholesterol** – **Lipoprotein** – **Triglycerides**	All asymptomatic Medicare patients (12-hour fast is required)		
Colorectal Cancer Screening – **Flexible sigmoidoscopy** (4 years, or once every 10 years after a screening colonoscopy – **Screening colonoscopy** (every 24 months at high risk; every 10 years not at high risk) – **Fecal occult blood test** (annually) – **Barium enema** (every 24 months at high risk; every 4 years not at high risk)	– Medicare patients age 50 and up – Screening colonoscopy: Those at high risk; no minimum age – No minimum age for having a barium enema as an alternative to a high risk screening colonoscopy if the patient is at high risk		
Diabetes Screening Tests (2 screening tests per year for patient diagnosed with pre-diabetes; 1 screening per year if previously tested, but not diagnosed with pre-diabetes or if never tested)	Medicare patients with certain risk factors for diabetes or diagnosed with pre-diabetes (patients previously diagnosed with diabetes aren't eligible for benefit)		
Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (Up to 10 hours of initial training within a continuous 12 month period; subsequent years up to 2 hours of follow-up training each year after initial year)	Medicare patients at risk for complications from diabetes, recently diagnosed with diabetes or previously diagnosed with diabetes (must certify DSMT need)		
Glaucoma Screening (annually for patient ins one of the high risk groups)	Patients with diabetes mellitus, family history of glaucoma, African-Americans age 50 and over, or Hispanic-Americans age 65 and up		
Prostate Cancer Screening (annually) – **Digital rectal exam** – **Prostate specific antigen test**	All male patients 50 or older		
Screening Pap Tests and Pelvic Examination (annually if high-risk, or childbearing age with abnormal Pap test within past 3 years; every 24 months for all other women)	All female Medicare patients		
Screening Mammography (annually)	All female patients 40 or older		
Vaccines – **Pneumococcal (once in a lifetime)** – **Seasonal Influenza (once per flu season in the fall or winter)** – **Hepatitis B (scheduled dosages required)**	All Medicare patients – May provide additional pneumococcal vaccinations based on risk and provided that at least 5 years have passed since previous dose – Hepatitis B, if medium/high risk		
Other:			