

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