Family Medical Associates of Raleigh
Your Family Comes First

Medicare Annual Wellness Visit

You are scheduled on

_____

At _____

Arrive @ _____

With _____

Please bring the following items:

☐ Insurance cards

☐ Completed Health Risk Assessment

☐ Completed Page 1 of Falls Risk Assessment

☐ Completed Depression Screening

☐ A bag of all current medications

☐ A list of all doctors, providers (like physical therapy), and/or suppliers (like diabetic supplies or home oxygen) you are currently using, and date of your last visit with them

☐ Any copay or balance due

Family Medical Associates of Raleigh
Your Family Comes First

3500 Bush Street
Raleigh, NC 27609
F: 919.875.9577
P: 919.875.8150
www.fmaraleigh.com

Dear Patient,

Our records indicate that you are due for an **Annual Medicare Wellness Visit**. The **Annual Medicare Wellness Visit** is a yearly visit which focuses on health promotion, disease prevention, and disease detection. It is different from a regular office visit because it does not deal with your specific health issues or concerns. Your health care provider may combine these two types of visits if time allows. In this instance your required co-pay and/or fees will apply to the office visit.

Your first Medicare Wellness Visit will include:

1. A review of your medical and social history,
2. Education and counseling about preventive services, and
3. Specific screening services, immunizations, and referrals if needed.

It will also include:

1. Height, weight, blood pressure, body mass index measurements,
2. A simple vision test,
3. Depression screening and Safety screening,
4. An offer to talk about End of Life Decision Making (labeled *Medical Care Decisions and Advance Directives*), and
5. A written plan letting you know which screenings, shots, and preventive services you will need over the next 5-10 years – this is called a Personal Prevention Plan.

You may also schedule **Annual Medicare Wellness Visits** to update your health information and your Personal Prevention Plan. Medicare typically covers the Annual Wellness Visit in full.

To help make the most of this visit with your doctor, please do the following ahead of time:

- Complete the enclosed Health Risk Assessment
- Complete the enclosed Depression Screening
- Complete Page 1 of the enclosed Falls Risk Assessment
- Review all enclosed materials and come prepared to ask questions
- Bring all forms to the next visit along with **a bag of all of your current medications**, **a list of all doctors, providers (such as Physical Therapy), and/or suppliers** (diabetic supplies, home oxygen) that you are currently seeing or using.
- Information on Living Wills and Advanced Directives are included in this packet. Please read and ask your provider if you would like a copy of the Health Care Power of Attorney and/ or Living Wills.

If you have any questions, please call us before your visit at 919-875-8150.

Sincerely,
The Providers of Family Medical Associates of Raleigh

Andrew J. Drabick, MD Conrad L. Flick, MD Josiah M. Carr II, MD Jennifer M. Jo, MD
Cheryl Y. Proctor, APRN, FNP-BC Cameron S. Hardee, APRN, ANP-BC Joan D. Britt, APRN, FNP-BC
M. Ryan Johnston, APRN, FNP-BC Angela M. Glass, APRN, FNP-BC Mary Jane Satre, APRN, FNP-BC

Medicare Wellness Visit – Health Risk Assessment (HRA)

MR # _____

1. ***How often do you exercise?***
   □ 1-2 times per week
   □ 3-4 times per week
   □ 5 or more times per week
   □ Never

2. ***How intense is your typical exercise?***
   □ Light (stretching, slow walking)
   □ Moderate (brisk walking)
   □ Heavy (jogging, swimming)
   □ Very Heavy (fast running, stair climbing)
   □ I am currently not exercising.

3. ***Do you currently smoke cigarettes or use other types of tobacco?***
   □ Yes
   - □ Cigarettes
   - □ Cigars
   - □ Chewing tobacco
   - □ Other

   □ No

4. ***Are you a former smoker or tobacco user?***
   □ Yes (Specify when you quit) _____
   □ No

5. ***How often do you drink alcohol?***
   □ 1-2 times per week
   □ 3-4 times per week
   □ 5 or more times per week
   □ Socially
   □ Never

6. ***How many servings of fruit or vegetables do you eat per day?***
   □ 1 serving
   □ 2 servings
   □ 3 or more servings
   □ None

7. ***How many servings of high fiber or whole grains do you eat per day?***
   □ 1 serving
   □ 2 servings
   □ 3 or more servings
   □ None

8. ***How many servings of high-fat/sugar foods do you eat per day?***
   □ 1 serving
   □ 2 servings
   □ 3 or more servings
   □ None

9. ***Do you wear seatbelts?*** □ Yes □ No

10. ***Have you driven intoxicated?*** □ Yes □ No

11. ***Do you use sunscreen?*** □ Yes □ No

12. ***In the past 6 months, have you felt down, depressed or hopeless?*** □ Yes □ No

13. ***In the past 6 months, have you lost interest or pleasure in doing things?*** □ Yes □ No

14. ***Have your feelings caused you stress or interfered with social interactions?*** □ Yes □ No

15. ***In general, are you satisfied with your life?***
    □ Yes □ No

16. ***How many hours of sleep do you usually get?***
    □ Less than 5 hours per night
    □ 5-7 hours per night
    □ 8-10 hours per night
    □ More than 10 hours per night

17. ***Do you have trouble hearing the TV or radio?***
    □ Yes □ No □ Sometimes

18. ***Do you strain or struggle listening to conversations?***
    □Yes □ No □ Sometimes

19. ***Do you need assistance around the home (such as preparing meals, taking medications, transportation, shopping and/or managing money)?***
    □Yes □ No □ Sometimes

20. ***Do you have or need grab bars in the bathroom?***
    □ Yes and I have grab bars
    □ Yes, but I do not have them
    □ No, I do not need grab bars

21. ***Do you have or need handrails & good lighting around stairwells?***
    □ Yes, I have handrails & adequate lighting for stairs
    □No, I need handrails and/or extra lighting for stairs
    □ No, I do not need handrails and/or extra lighting

22. ***Do you have smoke alarms at home?*** □ Yes □ No

23. ***Do you live alone?*** □ Yes □ No

24. ***Do you have a will or a living will?***
    □ Yes, I have a will
    □ Yes, I have a living will
    □ No, I do not have a will
    □ No, but I am interested in discussing it further

_____

Patient Name *Date*

Check Your Risk for Falling

Please circle "Yes" or "No" for each statement below			**Why it matters**
Yes (2)	No (0)	I have fallen in the past year.	People who have fallen once are likely to fall again.
Yes (2)	No (0)	I use or have been advised to use a cane or walker to get around safely.	People who have been advised to use a cane or walker may already be more likely to fall.
Yes (1)	No (0)	Sometimes I feel unsteady when I am walking.	Unsteadiness or needing support while walking are signs of poor balance.
Yes (1)	No (0)	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
Yes (1)	No (0)	I am worried about falling.	People who are worried about falling are more likely to fall.
Yes (1)	No (0)	I need to push with my hands to stand up from a chair.	This is a sign of weak leg muscles, a major reason for falling.
Yes (1)	No (0)	I have some trouble stepping up onto a curb.	This is also a sign of weak leg muscles.
Yes (1)	No (0)	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increases your chances of falling.
Yes (1)	No (0)	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
Yes (1)	No (0)	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines sometimes increase your chance of falling.
Yes (1)	No (0)	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
Yes (1)	No (0)	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.
Total _____		**Add up the number of points for each "yes" answer. If you scored 4 points or more, you may be at risk for falling. Discuss this brochure with your medical provider.**	

Centers for Disease Control and Prevention
Check for Safety: A Home Fall Prevention Checklist for Older Adults

Each year, thousands of older Americans fall at home. Many of them are seriously injured, and some are disabled. In 2002, more than 12,800 people over age 65 died and 1.6 million were treated in emergency departments because of falls.

Falls are often due to hazards that are easy to overlook but easy to fix. This checklist will help you find and fix those hazards in your home. The checklist asks about hazards found in each room of your home. For each hazard, the checklist tells you how to fix the problem. At the end of the checklist, you'll find other tips for preventing falls.

Floors: Look at the floor in each room.

Q: When you walk through a room, do you have to walk around furniture?

- Ask someone to move the furniture so your path is clear.

Q: Do you have throw rugs on the floor?

- Remove the rugs or use double-sided tape or a non-slip backing so the rugs won't slip.

Q: Are there papers, books, towels, shoes, magazines, boxes, blankets, or other objects on the floor?

- Pick up things that are on the floor. Always keep objects off the floor.

Q: Do you have to walk over or around wires or cords (like lamp, telephone, or extension cords)?

- Move coil or tape cords and wires next to the wall so you will not trip over them. If needed, have an electrician put in additional electrical outlets.

Stairs and Steps: Look at the stairs you use both inside and outside your home.

Q: Are there papers, shoes, books, or other objects on the stairs?

- Pick up things on the stairs. Always keep objects off stairs.

Q: Are some steps broken or uneven?

- Fix loose or uneven steps.

Q: Are you missing a light over the stairway?

- Have an electrician put in an overhead light at the top and bottom of the stairs.

Q: Do you have only one light switch for your stairs (only at the top or at the bottom of the stairs)?

- Have an electrician put in a light switch at the top and bottom of the stairs. You can also get light switches that glow.

Q: Has the stairway light bulb burned out?

- Have a friend or family member change the light bulb.

Q: Is the carpet on the steps loose or torn?

- Make sure the carpet is firmly attached to every step, or remove the carpet and attach non-slip rubber treads to the stairs.

Q: Are the handrails loose or broken? Is there a handrail on only one side of the stairs?

- Fix loose handrails or put in new ones. Make sure handrails are on both sides of the stairs and are as long as the stairs.

Kitchen: Look at your kitchen and eating area.

Q: Are the things you use often on high shelves?

- Move items in your cabinets. Keep things you use often on the lower shelves (about waist level).

Q: Is your step stool unsteady?

- If you must use a step stool, get one with a bar to hold on to. Never use a chair as a step stool.

Bathrooms: Look at all your bathrooms.

Q: Is the tub or shower floor slippery?

- Put a non-slip rubber mat or self-stick strips on the floor of the tub or shower.

Q: Do you need support when you get in and out of the tub or up from the toilet?

- Have a carpenter put grab bars inside the tub and next to the toilet.

Bedrooms: Look at all your bedrooms.

Q: Is the light near the bed hard to reach?

- Place a lamp close to the bed where it's easy to reach.

Q: Is the path from your bed to the bathroom dark?

- Put in a night-light so you can see where you're walking. Some night-lights go on by themselves in the dark.

Other Things You Can Do To Prevent Falls

- Exercise regularly. Exercise makes you stronger and improves your balance and coordination.
- Have your doctor or pharmacist look at all the medicines you take, even over-the- counter medicines. Some medicines can make you sleepy or dizzy.
- Have your vision checked at least once a year by an eye doctor. Poor vision can increase your risk of falling.
- Get up slowly after you sit or lie down.
- Wear shoes both inside and outside the house. Avoid going barefoot or wearing slippers.
- Improve the lighting in your home. Put in brighter light bulbs. Florescent bulbs are bright and cost less to use.
- It's safest to have uniform lighting in a room. Add lighting to dark areas. Hang lightweight curtains or shades to reduce glare.
- Paint a contrasting color on the top edge of all steps so you can see the stairs better. For example, use light color paint on dark wood.

Other Safety Tips

- Keep emergency numbers in large print near each phone.
- Put a phone near the floor in case you fall and can't get up.
- Think about wearing an alarm device that will bring help in case you fall and can't get up.

Patient Health Questionnaire (PHQ-9) - Depression Screening

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Circle the number in each column to indicate your answer)

	Not At All	Several Days	More Than Half the Time	Nearly Every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3

If you circled 2 or 3 to either of the questions above, continue on to the following questions.

3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading or watching television	0	1	2	3
8. Moving or speaking so slowly that other people have noticed. Or the opposite; being fidgety or restless and moving around a lot more	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

Add columns	+	+

Total score:

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	❑ Not difficult at all ❑ Somewhat difficult ❑ Very difficult ❑ Extremely difficult

Scoring Tool for PHQ-9 Depression Screening Tool

PHQ-9 Score	Depression Severity	Proposed Treatment Actions
0 – 4	None-minimal	None
5 – 9	Mild	Watchful waiting; repeat PHQ-9 at follow-up
10 – 14	Moderate	Treatment plan, considering counseling, follow-up and/or pharmacotherapy
15 – 19	Moderately Severe	Active treatment with pharmacotherapy and/or psychotherapy
20 – 27	Severe	Immediate initiation of pharmacotherapy and, if severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders
for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name:	Effective Date of Form:
Patient's First Name, Middle Initial:	Patient's Date of Birth:

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Attempt Resuscitation (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in **B, C**, and **D**.

Section B *Check One Box Only*

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions _____

Section C *Check One Box Only*

ANTIBIOTICS

☐ **Antibiotics if indicated**

☐ **Determine use or limitation of antibiotics when infection occurs**

☐ **No Antibiotics** (use other measures to relieve symptoms)

Other Instructions _____

Section D *Check One Box Only in Each Column*

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids if indicated**	☐ **Feeding tube long-term if indicated**
☐ **IV fluids for a defined trial period**	☐ **Feeding tube for a defined trial period**
☐ **No IV fluids** (provide other measures to ensure comfort)	☐ **No feeding tube**

Other Instructions _____

Section E *Check The Appropriate Box*

DISCUSSED WITH AND AGREED TO BY:

Basis for order must be documented in medical record.

☐ Patient	☐ Majority of patient's reasonably available parents and adult children
☐ Parent or guardian if patient is a minor	
☐ Health care agent	☐ Majority of patient's reasonably available adult siblings
☐ Legal guardian of the patient	
☐ Attorney-in-fact with power to make health care decisions	☐ An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient
☐ Spouse	

MD/DO, PA, or NP Name (Print):	**MD/DO, PA, or NP Signature and Date** (Required):	**Phone #:**

Signature of Patient, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative
(Signature is required and must either be on this form or on file)

I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.

If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.

You are not required to sign this form to receive treatment.

Patient or Representative Name (print)	Patient or Representative Signature	Relationship (write "self" if patient)

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Contact Information

Patient Representative:	Relationship:	Phone #: Cell Phone #:	
Health Care Professional Preparing Form:	Preparer Title:	Preferred Phone #:	Date Prepared:

Directions for Completing Form

Completing MOST

- MOST must be reviewed and prepared by a health care professional in consultation with the patient or patient representative.
- MOST is a medical order and must be signed and dated by a licensed physician (MD/DO), physician assistant, or nurse practitioner to be valid. **Be sure to document the basis for the order in the progress notes of the medical record.** Mode of communication (e.g., in person, by telephone, etc.) also should be documented.
- The signature of the patient or his/her representative is required; however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record and "on file" must be written in the appropriate signature field on the front of this form or in the review section below.
- Use of original form is required. **Be sure to send the original form with the patient.**
- MOST is part of advance care planning, which also may include a living will and health care power of attorney (HCPOA). If there is a HCPOA, living will, or other advance directive, a copy should be attached if available. **MOST may suspend any conflicting directions in a patient's previously executed HCPOA, living will, or other advance directive.**
- **There is no requirement that a patient have a MOST.**
- MOST is recognized under N. C. G en. Stat. 90-21.17.

Reviewing MOST

Review of the MOST form is recommended when:

- The patient is admitted to and/or discharged from a health care facility; or
- There is a substantial change in the patient's health status.

This MOST must be reviewed if:

- The patient's treatment preferences change.

If MOST is revised or becomes invalid, draw a line through Sections A – E and write "VOID" in large letters.

Revocation of MOST

A patient with capacity or the patient's representative (if the patient lacks capacity) can revoke the MOST at any time and request alternative treatment based on the known preferences of the patient or, if unknown, the patient's best interests.

Review of MOST

Review Date	Reviewer and location of review	MD/DO, PA, or NP Signature (required)	Signature of patient or representative (preferred)	Outcome of Review
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

NCDHHS/DHSR/OEMS
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North Carolina Department of Health and Human Services • Division of Health Service Regulation • Office of Emergency Medical Services
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