NAME: ____________________________ DOB: __________________ TODAY'S DATE: _____________

A WORD TO OUR PATIENTS ABOUT MEDICARE AND WELLNESS CARE

Dear Patient,

In order to allow for more pricing transparency, we feel it is necessary to clarify wellness care. We want you to receive wellness-care-health care assessments that may lower your risk of illness or injury. Medicare pays for some wellness care, but it does not pay for all the wellness care you may need. We want you to know about your Medicare benefits and maximize their usefulness.

The term "physical" is often used to describe wellness care. However, Medicare **does not** pay for traditional, head to toe physical. Medicare **does** pay for a wellness visit once a year to identify health risks and to help you reduce them.

The Medicare Wellness Visit includes the following assessments:

-Screening to detect depression, risk of falling, cognitive, and other problems.

-A limited physical exam to check your blood pressure, weight, and other things depending on your age, gender and level of activity. However, we will be performing a full exam as we feel that it is important to be diligent and thorough in your care.

-Recommendations for other wellness services and healthy lifestyles changes.

A wellness visit **does not** allow time to address **new or existing** health problems properly. These would qualify as separate services and require a longer appointment. Please let our scheduling staff know if you need the physician's help with a health problem or more pressing concerns than the wellness visit. We may need to schedule a separate appointment to complete the wellness at a later date. If performed, a separate charge applies to these services.

We hope that this helps clarify your Medicare wellness benefits.

SCREENING AND PREVENTATIVE SERVICES

Screening/Test	Please write the most recent dates for the following screenings:
Pneumococcal Vaccines (ex: Prevnar/ Pneumovax)	Date Completed: ___________________________
Influenza Vaccine	Date Completed: ___________________________
Shingles Vaccine	Date Completed: ___________________________
COVID Vaccine	Date Completed: ___________________________
RSV Vaccine	Date Completed: ___________________________
TDAP Vaccine	Date Completed: ___________________________
Lung Cancer Screening	Date Completed: ___________________________ Results Normal? YES NO UNSURE
Mammogram Screening	Date Completed: ___________________________ Results Normal? YES NO UNSURE
Bone Density Screening	Date Completed: ___________________________ Results Normal? YES NO UNSURE
Colorectal Cancer Screening	Date Completed: ___________________________ Results Normal? YES NO UNSURE
PAP Smear (females only)	Date Completed: ___________________________ Results Normal? YES NO UNSURE
PSA Screening (males only)	Date Completed: ___________________________ Results Normal? YES NO UNSURE
Eye Exam	Date Completed: ___________________________ Results Normal? YES NO UNSURE

PHQ-9 Questionnaire

Over the **last 2 weeks,** how often have you been bothered by the following problems?	Not at	Several Days	More than half the days	Nearly everyday
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself- or that you are a failure or that you have let yourself or family down	0	1	2	3
Trouble concentrating on things such as reading or watching television	0	1	2	3
Moving or speaking so slowly that other people have Noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thought that you would be better off dead, or Hurting yourself	0	1	2	3

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

List of Providers:

Primary care Physician/Provider(s):

Clinic/Provider Name	Location

Specialist(s):

Clinic/Provider Name	Location	Specialty

Alternative Medicine Providers: (chiropractor, acupuncturist etc.)

Clinic/Provider Name	Location	Specialty

Preferred Pharmacy(s): Name/Location

Pharmacy Name	Location

Dentist:

Name	Location

Medicare Wellness: Health Risk Assessment

Living Situation

1) What is your living situation today?
   ___ I have a steady place to live
   ___ I have a plot live today, but I am worries about losing it in the future
   ___ I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
2) Think about the place you live. Do you have problems with any of the following?
   CHOOSE ALL THAT APPLY
   ___ Pests such as bugs, ants or mice
   ___ Mold
   ___ Lead paint or pipes
   ___ Lack of heat
   ___ Oven or stove not working
   ___ Smoke detectors missing or not working
   ___ Water leaks
   ___ None of the above

Food

3) Within the past 12 months, are you worries that your food would run out before you got money to buy more.
   ___ Often true
   ___ Sometimes true
   ___ Never true
4) Within the past 12 months, the food you bought just did not last and you did not have money to get more.
   ___ Often true
   ___ Sometimes true
   ___ Never true

Transportation

5) In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things need for daily living?
   ___ Yes
   ___ No

Utilities

6) In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
   ___ Yes
   ___ No
   ___ Already shut off

Safety

Because violence and abuse happen to a lot of people and affects their health, we are asking the following questions:

7) How often does anyone, including family and friends, physically hurt you?
   ___ Never (1) ___ Rarely (2) ___ Sometimes (3) ___ Fairly Often (3) ___ Frequently (4)
8) How often does anyone, including family and friends, insult or talk down to you?
   ___ Never (1) ___ Rarely (2) ___ Sometimes (3) ___ Fairly Often (3) ___ Frequently (4)
9) How often does anyone, including family and friends, threaten you with harm?
   ___ Never (1) ___ Rarely (2) ___ Sometimes (3) ___ Fairly Often (3) ___ Frequently (4)
10) How often does anyone, including family and friends, scream or curse at you?
   ___ Never (1) ___ Rarely (2) ___ Sometimes (3) ___ Fairly Often (3) ___ Frequently (4)
11) In general, would you say your health is:

   ___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

12) How have things been going for you during the past 4 weeks?
   ___ Very well; could hardly be better ____ Pretty well
   ___ Good and bad parts about equal ____ Pretty bad
   ___ Very bad; could hardly be worse
13) How confident are you that you can control and manage most of your health problems/issues?
   ___ Very Confident ___ Somewhat confident ___ Not very confident
   ___ I do not have any health problems
14) How often in the **last 4 weeks,** have you been bothered by any of the following problems?

	Never	Seldom	Sometimes	Often	Always
Falling or dizzy when standing					
Sexual problems or concerns					
Trouble eating well					
Teeth or denture problems					
Problems using the telephone					
Problems sleeping					
Tiredness or fatigue					

15) Have you fallen two or more times in the past year? ___ Yes ___ No

16) Are you afraid of falling? Do you feel unsteady? ___ Yes ___ No

17) HOME SAFETY CHECKLIST
- Are entrance ways well lit? ___ Yes ___ NO
- Are sidewalks/entrance ways maintained? ___ Yes ___ No
- Is a carbon monoxide detector installed? ___ Yes ___No
- Are smoke detectors installed? ___ Yes ___ No
- Are all medicines kept in original containers with original labels intact? ___ Yes ___ No
- Do you throw out all unidentified or out of date medications? ___ Yes ___No

18) How often do you have trouble taking medications the way you have been told to take them?
___ I do not have to take medicine
___ I always take them as directed
___ Sometimes I take them as directed
___ I seldom take them as directed

19) Do you have difficulty driving your car?
___ Yes, often ___ Sometimes ___ No ___ N/A – I do not use a car

20) Do you always fasten your seat belt when you are in a car?
___ Yes, always ___ Yes, sometimes ___ No

21) How often in the **last 4 weeks** have you experienced the following:

	Never	Seldom	Sometimes	Often	Always
Straining to understand conversation					
Trouble hearing in a noisy background					
Misunderstanding what others are saying					

22) During the **last 4 weeks,** how much have you been bothered by feelings of anxiety, depression, irritability or sadness?
___ Not at all ___ Quite a bit ___ Slightly ___ Moderately ___ Extremely

23) During the **last 4 weeks,** has your physical or emotional health limited your social activities with family and friends?
___ Not at all ___ Quite a bit ___ Slightly ___ Moderately ___ Extremely

24) During the **last 4 weeks,** how much bodily pains have you generally had?
___ Not at all ___ Quite a bit ___ Slightly ___ Moderately ___ Extremely

25) Do you have someone who is available to help you if you needed or wanted help?
___ Yes, as much as I want/need ___ Yes, some ___ No, not at all

26) Because of any health problems, do you need the help of another person with your personal care needs, such as eating, bathing, dressing, or getting around the house?
____ Yes ____ No

27) Because of any health problems, do you need the help of another person with shopping, preparation of meals, or house work?
   ____ Yes ____ No
28) Can you handle your own money without help?
   ____ Yes ____ No
29) During the **last 4 weeks,** did you exercise for about 20 minutes, 3 or more days a week?
   ___ Yes, most of the time
   ___ Yes, some of the time
   ___ No, I usually do not exercise
   ___ No, I am not currently exercising
30) When you exercise, how intensely do you typically exercise?
   ___ Light (stretching/slow walking)
   ___ Moderate (brisk walking)
   ___ Heavy (jogging/swimming)
   ___ Very heavy (running/stair climbing)
31) Are you a smoker/tobacco user?
   ___ No-never ___ No-former ___ Yes, and I am interested in quitting ___ Yes, I am not ready to quit
32) In the **last 7 days,** how many of those days did you drink alcohol? _____ days
33) On the days that you drank alcohol, how often did you have 4 or more drinks?
   ___ Never ____ Once during the week ____ 2-3 times during the week ___ More than 3 times during the week

CAGE ASSESSMENT

Question	YES	NO
Have you ever felt you should **C**ut down on your drinking?		
Have people **A**nnoyed you by criticizing your drinking?		
Have you ever felt bad or **G**uilty about your drinking?		
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?		
TOTAL		
Scoring: Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant.		

YAY YOU ARE DONE!

Thank you for completing this Medicare Wellness Health Risk Assessment 😊

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

Physician Orders for Life-Sustaining Treatment (POLST)-Florida

Follow these orders until orders are reviewed. These medical orders are based on the patient's **current** medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name	Patient First Name	Middle Int.
Date of Birth: (mm/dd/yyyy) ___ ___ ___	Gender ☐ **M** ☐ **F**	Last 4 SSN: ☐ ☐ ☐ ☐

If the patient has decision-making capacity, the patient's presently expressed wishes should guide his or her treatment

A Check One — CARDIOPULMONARY RESUSCITATION (CPR): Patient is unresponsive, pulseless, and not breathing.

☐ **Attempt Resuscitation/CPR**

☐ **Do Not Attempt Resuscitation/DNR**

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

B Check One — MEDICAL INTERVENTIONS: If patient has pulse and is breathing.

☐ **Full Treatment – goal is to prolong life by all medically effective means.**
In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and /or intensive care unit if indicated.
Care Plan: Full treatment including life support measures in the intensive care unit.

☐ **Limited Medical Interventions – goal is to treat medical conditions but avoid burdensome measures**
In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP).
Transfer to hospital if indicated. Generally avoid the intensive care unit.
Care Plan: Provide basic medical treatments.

☐ **Comfort Measures Only (Allow Natural Death) – goal is to maximize comfort and avoid suffering**
Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location. Consider hospice or palliative care referral if appropriate.**
Care Plan: Maximize comfort through symptom management.

Additional Orders:______________________________

C Check One — ARTIFICIALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible.

☐ **Long-term artificial nutrition by tube**.

☐ **Defined trial period of artificial nutrition by tube.**

☐ **No artificial nutrition by tube.**

Additional Instructions: ______________________________

D Check One — HOSPICE or PALLIATIVE CARE (complete if applicable) - consider referral as appropriate

☐Patient/Resident Currently enrolled in Hospice Care Contact:__________	☐Patient/Resident Currently enrolled in Palliative Care Contact:__________	☐Not indicated or refused

SIGNATURES

Print Physician Name	MD/DO License #	Phone Number
Physician Signature **(mandatory)**	Date	
Print Patient/Resident or Surrogate/Proxy Name	Relationship (write 'self' if patient)	
Patient or Surrogate Signature **(mandatory)**	Date	

SEND FORM WITH PATIENT WHENEVER TRANFERRED OR DISCHARGED

Use of original form is strongly encouraged. Photocopies and facsimiles of completed POLST are legal and valid.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

E Check All That Apply

DOCUMENTATION OF DISCUSSION:

☐Patient (Patient has capacity) ☐Health Care Representative or surrogate

☐Parent of minor ☐Court-Appointed Guardian ☐Other (proxy)

Other Contact Information

Name of Guardian, Surrogate or other Contact Person	Relationship	Phone Number/Address	
Name of Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professionals

Completing POLST

- Must be completed by a health care professional based on medical indications, a discussion of treatment benefits and burdens, and elicitation of patient preferences.
- POLST must be signed by a MD/DO to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- POLST must be signed by patient/resident or healthcare surrogate/proxy to be valid.

Using POLST

- Any section of POLST not completed implies full treatment for that section.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.
- A semi-automatic external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation."
- Oral fluids and nutrition must always be offered if medically feasible.
- When comfort cannot be achieved in the current setting, the person, including someone with "comfort measures only," should be transferred to a setting able to provide comfort, such as a hospice unit.
- A person who chooses either "comfort measures only" or "limited additional interventions" should not be entered into a Level I trauma system.
- An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."
- A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment."
- A person with capacity or the surrogate/proxy (if patient lacks capacity) can revoke the POLST at any time and request alternative treatment.

Reviewing POLST

This POLST should be reviewed periodically and a new POLST completed if necessary when:

(1) The person is transferred from one care setting or care level to another, or

(2) There is a substantial change in the person's health status, or

(3) The person's treatment preferences change.

To void this form, draw line through sections A through D on page 1 and write "VOID" in large letters.

Review of this POLST Form

Review Date	Reviewer	Location of Review	Review Outcome
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed
			☐ No Change ☐ Form Voided ☐ New form completed

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED