REFERAL FORM

JesusArenasMD@cad.com	MD ID: Comes here...

Name of Agency : Tree of Life HH Care

Home Health Service

- [x] For Skill Nursing Services
- [ ] For Physical Therapy Treatment
- [ ] For Occupational Therapy

Treatment

- [x] Pain Management
- [ ] Psychiatry
- [ ] Neurology
- [ ] Wound Care Specialist

Lab(s) _____

- [x] Lipid Panel
- [ ] Renal Profile
- [ ] Urine Culture And Sensitivity
- [ ] ANS/ QSART Test (Evaluation For Autonomic Nervous System)
- [ ] EKG
- [ ] TSH, T3, T4
- [ ] CBC
- [ ] BMP
- [ ] Cardiac Enzymes
- [ ] CT
- [ ] Liver Profile
- [ ] Echocardiogram
- [ ] CMP
- [ ] Respiratory Swab
- [ ] A1C
- [ ] B 12
- [x] Ultrasound Bilateral Lower Extremities For DVT
- [ ] Urinalysis With PCR If (+)
- [ ] PSA
- [ ] Vitamin D
- [ ] Chest X-Ray
- [ ] Pneumonia Sputum

Provider Name: Name Signature: _____
Date: Date here

Medical Provider Name: Name Signature: _____
Date: Date here

ADMISSION ORDERS

NEW MEDICATIONS ☐ Spanish Translation

#	Date	Medication Name	Dose	Route	Frequency	Purpose
1	2024-06-12	regix	daily 1	SQ	Topical	QD
2	2024-06-19	panadol	as required	INJ	Topical	PRN

Treatment Orders

☐ Discontinue

☑ Refill Medications

DIET	☐ Dash ☑ Renal ☐ Diabetic ☐ Mechanical Soft ☐ Pureed ☐ Thickened Liquid
DME	☐ Cane ☑ WheelChair ☐ Ankle Support ☐ ShowerChair ☐ Walker ☐ Compression Stockings ☐ BP Machine ☐ Commode ☐ Back Support ☐ Knee Support
SUPPLIES	☐ Pull Ups Small ☐ Under Pads ☐ Bed Pan ☐ Pull Ups Medium ☐ Pull Ups Large ☐ Glucose Test Strips

Refer To:

☑ Home Health Due To	Name of Health Agency: Tree of Life HH Care Name of Hospice Agency: hospice		
☑ Cardiology	Name cardio	Tel: cardio tel	Location: cardio loc
☑ WoundCare	Name wound name	Tel: wound tel	Location: wound loc
☑ Surgery Procedure: surg procedure	Name surg name	Tel: 132156	Location: surg loc
☑ Pain Specialist	Name name	Tel: 456789	Location: location
☑ Orthopaedic	Name ortho name	Tel: 4678979	Location: ortho loc

Laboratory and Diagnostics

☐ Ans/QSART Test Evalution For Automatic Nervous System	☐ Ultrasound Bilateral Lower Extremities Arteries And Veins	☐ Echocardiogram
☐ AIC	☐ Pneumonia Sputum	☐ B12
☐ Chest X-Ray, VI	☐ Lithium Level	☐ Renal Profile
☐ VitaminD	☐ EKG	☐ BMP
☐ Liver Profile	☐ CBC	☐ CT
☑ Urine Culture & Sensitivity	☐ TSH, T3, T4	☐ CMP
☐ PSA	☐ Cardiac Enzymes	☐ LIPID Panel

Provider Name: Name Signature: _____
Date: Date here

Physician Name: Name Signature: _____
Date: Date here

IMPRESSION PLAN

☐ Transitional Care

Swelling	Patient may have swelling. It is the enlargement of organs, skin, or other body parts. It is caused by a buildup of fluid in the tissues. The extra fluid can lead to a rapid increase in weight over a short period of time
Tremors	Patient may have cyclical movement of a body part that can represent either a physiologic process or a manifestation of disease. Intention or action tremor, a common manifestation of cerebellar diseases, is aggravated by movement. In contrast, resting tremor is maximal when there is no attempt at voluntary movement, and occurs as a relatively frequent manifestation of parkinson disease.
Catheter	Patient may have a tubular medical device for insertion into canals, vessels, passageways, or body cavities for diagnostic or therapeutic purposes (as to permit injection or withdrawal of fluids or to keep a passage open)

Advanced Care Planning: Advanced care planning with patient, time spent **15** minutes. Reviewed care plan options such as code status, intubation and hospitalization. Reviewed risks of cardiac resuscitation including rib fracture. Reviewed prolong life expectancy and benefit to aggressive care and treatment.

Orders: AS ATTACHED

Discussion Notes:

Current condition, medication regimen, plan of care as above discussed. Continue current medications and plan of care. Frail elderly, on medications requiring regular monitoring. Follow labs closely. Medications prescribed using electronic prescribing system. I verify that a total of 60 minutes was spent on this encounter by the Nurse Practitioner directly. Follow-up visit mentioned in plan.

INITIAL ASSESMENT

☐ Initial Visit	☑ Follow Up Visit / ☐ Recert Visit	Sex : ☑ M / ☐ F	Location patient is accessed: ☐ Home Visit ☑ Boarding Care

Chief Complaint

ALLERGIES

Drug / Food	Reaction
Name of the drug	Reaction Description

☐ Penicillin ☐ Sulfa ☐ NO KNOWN ALLERGIES

Functional Limitations		Activities Permited	
☐ Weakness	☑ Ambulation	☐ Up As Tolerated	☑ Dependent At Home
☐ Amputation	☐ Bowel/Bladder	☐ Independent At Home	☐ Bed-Bound
☐ Confused	☐ Contacture	☐ Cane	☐ Chair Bound
☐ Hearing	☐ Legally Blind	☐ Complete Bedrest	☐ Crutches
☐ Paralysis	☐ SOB Minimum Exertion	☐ Exercise Provided	☐ Partial Weight
☐ Speech	☐ Vision Deficit	☐ Walker	☐ Wheelchair

PAST MEDICAL HISTORY

☐ Chronic Back Pain	☑ Neuropathy	☐ GERD	☐ Rheumatoid Arthritis	☐ Over Active Bladder	☐ Gout	☐ Depression	☐ Sciatica
☐ Osteoporosis	☐ Insomnia	☐ Venous Insufficiency	☐ PVD	☐ Glaucoma	☐ Bipolar	☐ Schizophrenia	☐ Headache's
☐ Bronchitis	☐ Mild Memory Loss	☐ CAD	☐ Cobalamin Deficient	☐ Dementia	☐ BPH	☐ Parkinson's	☐ Cancer
☐ MI	☐ Cardiac Arrhythmia	☐ Asthenia	☐ Weakness	☐ Iron Anemia	☐ Hypothyroidism	☐ Anxiety	☐ COPD
☐ Muscle Weakness	☐ UTI	☐ Tobacco Use	☐ Chronic Falls	☐ CHF	☐ A.FIB	☐ Protein Deficiency	☐ Herniated Disc
☐ Angina Pectoris	☑ Stroke	☐ Diabetes Type 1 2	☐ Diarrhea	☐ Hypertension	☑ Tachycardia	☐ Asthma	☐ CKD
☐ Alzheimer's	☐ Arthritis	☐ Chronic Migraine	☐ DVT	☐ Hypertriglyceridemia	☐ Shingles	☐ HLD	☐ Constipation
☐ HIV	☐ Seizure	☐ Vertigo	☐ Vit. D Deficient	☐ Unsteady Gait			

PAST SURGICAL HISTORY

☐ CABG	☐ Hernia
☑ Knee Replacement (R)	☑ Knee Replacement (L)
☐ Hip Replacement (R)	☑ Hip Replacement (L)
☑ Appendectomy	☐ Cholecystectomy
☐ Cardiac Stents	☐ Hysterectomy
☐ Pacemaker	☐ Cataracts

Social History

Tobacco / THC	☑ Yes	☐ No	☐ Daily	☑ Socially	☐ Occasionally
ETOH/Alcohol	☑ Yes	☐ No	☐ Daily	☐ Socially	☑ Occasionally
Drugs	☐ Ecstasy	☑ Methamphetamines	☑ Cocaine	☐ Heroin	

REVIEW OF SYSTEM / PHYSICAL EXAMINATION

VITALS

HT	WT	TEMP	BP	HR	RR	02 SAT
Date	Meds	Dos	Rout	Freq	Purpose	Purpose

System	WNL	FINDINGS					
General		☐ Loss Weight	☑ Anorexia	☐ Immobile	☐ Cachectic	☐ Alert	☐ Awake
		☐ Inattentive	☐ Recentlyfell	☑ Obese	☐ Chills	☐ Fatigue	☐ Gain Weight
		☐ Fever	☐ Ataxia	☐ Limited Ambulation	☐ Night Sweats		
Head		☐ Vertigo	☐ Masses	☑ Contusion	☐ Seizures	☐ Syncope	☐ Headache
		☐ Abrasion	☐ Dizziness	☑ Trauma			
Neck, Axilla, Breasts		☐ Rash	☐ Lymphadenopath	☑ Bleeding	☐ Discharge	☐ Tenderness	☐ Dowager Hump
		☐ Pain Masses	☑ Numbness And Tingling In Neck	☐ Erythema	☐ Tracheamidline	☑ Breasts Asymmetric	☐ Neck Pain

System	WNL	FINDINGS
Eyes		☐ Decreased Vision ☐ Diplopia ☐ PERRLA ☐ ArcusSenilis ☑ Involuntary Blinking ☑ Strabismus ☐ Blurring ☐ Dry Eyes ☐ Glasses ☐ Erythema
Ears		☑ Good Light Reflex ☐ Erythematous ☐ Pain ☐ Deafness ☐ Bulging ☐ External Hearing Aid ☑ Tinnitus ☑ Decreased Hearing ☐ Discharge
Nose		☐ Congestion ☐ Redness ☑ Rhinorrhea ☐ Epistaxis
Mouth		☐ Dysphagia ☑ Redness ☑ Missing Teeth ☐ Sticking Out Tongue ☐ Discharge: Color ☐ Sores ☐ Lip Smacking ☐ Dentures ☐ Dysphasia ☐ Sore Throat ☐ Mucosa: Dry ☐ Gingival Bleeding
Cardiovascular		☐ At Rest ☑ Bradycardia ☐ Pale ☐ Orthopnea ☐ Palpitations ☐ Shortness Of Breath: ☑ Minimum ☐ Arrhythmia ☐ Tachycardia ☐ Known Murmur ☑ Chest Pain ☐ Regular Irregular Rhythm ☐ JVD ☐ Pacemaker ☐ Edema ☐ Moderate Exertion ☐ Extremities Pulses: +2 ☐ Sinus Rhythm ☐ Fatigue
Pulmonary		
Abdomen		☐ RUQ ☐ LUQ ☐ Hernia ☐ Hard ☐ Distended ☐ Heartburn ☐ Pain ☐ Diarrhea ☑ Vomiting ☐ RLQ ☐ Nausea ☐ Constipation ☑ Non-Tender Masses: Loc. ☐ Soft ☐ Hypoactive ☐ Tenderness:Loc: ☐ BS Present: ☐ Hyper ☐ LLQ
Genitourinary		☐ Dysuria ☑ Hematuria ☐ Increased Frequency ☐ Foul Odor ☐ Incontinence ☑ Cloudy Urine ☐ Catheter
Rectal		☐ Bleeding ☑ Rash ☑ Hemorrhoids ☐ Discharge ☐ Wearing Diaper ☐ Redness
Upper extremities		☐ Radial Pulse: R ☑ Radial Pulse: Absent ☐ Numbness And Tingling Loc: L ☐ Weakness Loc: L ☐ Heberden's Node ☐ AV Shunt : ☐ Radial Pulse: L ☑ Numbness And Tingling Loc: R ☐ Radial Pulse: Weak ☐ Limited Movements ☐ Itchiness ☑ Edema Pitting ☐ AV Shunt :R ☐ Swelling Loc : L ☐ Weakness Loc: R ☐ Shaking ☐ Redness ☐ Non-Pitting: Loc: R ☐ AV Shunt :L ☐ Non-Pitting: Loc: L ☐ Warm ☐ Swelling Loc : R ☐ Cold
Lower extremities		☐ Limited Movements ☐ Weakness Loc ☐ Swelling Loc ☐ Hallux Valgus ☐ Itchiness ☐ Redness ☐ Shaking ☐ Edema Pitting ☐ Weakness: Loc: R ☐ Weakness: Loc: L ☑ Swelling Loc: R ☐ Swelling Loc: L ☑ Numbness And Tingling Loc: ☐ Numbness And Tingling Loc: R ☑ Numbness And Tingling Loc: L ☐ Cold ☐ Warm ☐ Pedal Pulse: ☐ Pedal Pulse: Weak ☐ Pedal Pulse: Absent ☐ Pedal Pulse: R ☐ Pedal Pulse: L
Skin		
Nutrition		
MUSCLE SKELETAL	WNL...	☐ Stiffness Arm: L ☐ Stiffness Arm: R ☐ Stiffness Leg: L ☐ Stiffness Leg: R ☐ Weakness Arm: L ☑ Weakness Arm:R ☑ Weakness Leg: L ☐ Weakness Leg: R ☐ Kyphosis ☑ Decreased ROM ☐ Lumbar Pain
Endocrine		
Pelvic		☐ Stiffness ☐ Hernia ☑ Erythema ☐ Rash ☐ Pain ☐ Trauma ☐ Decreased Range Of Motion
Neurological		☐ Facial Weakness ☐ Impaired Balance ☐ Numbness ☐ Dizziness ☐ Seizure ☐ Tremors ☐ Slurred Speech ☐ Grimacing ☐ Handgrip Weak: ☐ Handgrip Weak: L ☐ Handgrip Weak: R ☐ Paralysis:

System	WNL	FINDINGS
		☐ Paralysis: L ☐ Paralysis: R ☑ Mild Cognitive Delay/Learning Difficulties ☐ Half Body Weakness: ☑ Half Body Weakness: L ☐ Half Body Weakness: R ☐ Facial Drooping: ☑ Facial Drooping: L ☐ Facial Drooping: R ☐ Stuttering ☐ Non Verbal ☐ Unsteady Gait
Mental		☐ Lability Of Mood ☑ Hallucinations ☐ Delusions ☐ Depression ☐ Somnolence ☑ Insomnia ☐ Anxious ☐ Disoriented ☐ Lethargic ☐ Forgetful ☑ Confused ☐ Hearing Voices ☐ Oriented: ☐ Person ☐ Time ☐ Place

ASSESSMENT/DIAGNOSIS

Diagnosis comes here...

PLAN

☐ Continue Current Medications/Treatment	☐ Follow Up In Weeks With PCP	☐ Labs/Diagnostics: See AdmissionOrders
☑ PT/OT/HH For Disease Or Pain Management	☑ Referrals: See Admission Orders	☐ Refill Medications
☐ Wellness/Preventive Intervention:		

Provider Name: Name Signature: _____
Date: Date here

Physician Name: Name Signature: _____
Date: Date here

FACE TO FACE ENCOUNTER

Home Health: Home health name... **Date of Service** Date here...

I certify that this patient is under my care and that I, or an allowed Nurse practitioner or Physician's assistant working in collaboration with me, had a face-to-face encounter that meets physician face-to-face-encounter requirements with this patient on:

Month Month here... **Day** Day here... **Year** Year here...

Clinical Summary of Findings from Face-to-Face Encounter in Support of Home Health Need:
(Require up to 90 days prior to initial SOC, is relevant to the reason for the patient's need for home health services, or within 30 days after the start of care if the 90-day prior encounterdid not take place.)

Medical Condition Related to Home Health Services:
The encounter with the patient was in whole, or in part, for the following medical condition, which is the primary reason for home health care because

☐ HTN	☐ HLD	☐ DIABETES Type 1 2	☐ GERD / Gout
☐ COPD / Asthma / Dyspnea	☐ Limited Ambulation	☑ OA	☐ Depression
☐ Anxiety	☐ Insomnia	☐ Constipation	☐ Hyperthyroidism
☐ BPH/ Overactive Bladder	☐ Memory Loss	☐ Dizziness	☐ Tobacco Use
☐ Vitamin D Deficiency	☑ Neuropathy / Sciatica	☐ Muscle Cramp	☐ Ble Weakness/Ble Edema
☐ PVD / DVT / CAD	☐ Schizophrenia	☐ Arthritis / Osteoarthritis	☐ Iron Deficiency Anemia
☐ Stroke	☐ Mild Mental Retardation	☐ Herniated Disc	☐ Angina Pectoris
☐ Venous Insufficiency	☐ Hypertensive Heart Disease Without Heart Failure	☐ LBP, Knee / Shoulder Pain	☐ Hypothyroidism
☐ Myocardial Infarction	☐ ATRIAL Fibrillation	☐ Dementia / Alzheimer's	☐ Cancer
☐ Seizure	☐ Hypertensive Heart Disease With Heart Failure	☐ Nausea/Vomit/Diarrhea	☑ Congestive Heart Failure
☐ Hyperlipidemia	☐ Chronic Migraines	☐ Parkinson's	☐ History Of Falls
☐ Chronic Kidney Stage 1 / 2 / 3	☐ SOB With Exertion	☐ Bipolar / Psychosis	☐ Arrhythmia
☐ Asthenia / Unsteady Gait			

I further certify that, based on my findings, this patient is homebound (i.e. absences from home require considerable and taxing effort, and for medical reasons or religious services, or infrequently, or of short duration when for other reasons) due to the following services that are medical necessary from home health (Check allthat apply):

☐ Skilled Nursing	☑ Ostomy Care	☐ Speech Pathology	☐ Cardiac/CHF Care
☐ Home Health Aide	☑ Occupational Therapy	☐ Physical Therapy	☐ Medical Management
☐ Diabetic Care	☐ Neurological Care	☐ Foley Catheter Care	☐ Stroke Care
☐ G.T. Care	☐ Wound Care	☐ Strengthening/Balance	☐ Social Worker
☐ Dialysis Care / AV Fistula	☐ Psychiatry	☐ Orthopedic Care	☑ COPD Care

Certificate of Homebound Status:
My clinical findings from this encounter support the patient is homebound due to:

☐ Requires The Assistance Of 1-2 People To Ambulate	☐ Poor Ambulation – Prone To Falls	☐ Medical Restrictions: Open Draining Wound, Legs Elevated All Times	☑ Impaired Ability To Unsafe To Drive
☐ Confusion/Disorientation	☑ Unable To Leave Home Without Maximum Assistance And/Or Effort	☐ Debilitating Dizziness	☑ Compromised Mental Status
☑ Difficult And Taxing Effort To Leave Home	☐ Unable To Ambulate	☑ Requires An Assistive Device To Ambulate	☐ Post-Op Weakness
☐ Unsteady Gait With Assistive Device	☐ Debilitating Dyspnea On Exertion	☐ Unable To Negotiate Stairs	

Provider Name: Name Signature: _____
Date: Date here

Physician Name: Name Signature: _____
Date: Date here

TELE MEDICINES

Home Health: Home health name... **Date of Service** Date here...

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☐ Confusion/Disorientation	☐ Unable To Leave Home Without Maximum Assistance And/Or Effort	☑ Debilitating Dizziness	☑ Compromised Mental Status
☐ Difficult And Taxing Effort To Leave Home	☐ Unable To Ambulate	☑ Requires An Assistive Device To Ambulate	☐ Post-Op Weakness
☐ Unsteady Gait With Assistive Device	☐ Debilitating Dyspnea On Exertion	☐ Unable To Negotiate Stairs	

Provider Name: Name Signature: _____
Date: Date here

Physician Name: Name Signature: _____
Date: Date here

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

EMSA #111B
(Effective 10/1/2014)

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

Patient Last Name: Zain	Date Form Prepared: 2024-06-18
Patient First Name: Muhammad	Patient Date of Birth: 1996-07-30
Patient Middle Name:	Medical Record# 123456789

A Check One

CARDIOPULMONARY RESUSCITATION (CPR): If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

- [x] Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)
- [ ] Do Not Attempt Resuscitation/DNR (Allow Natural Death)

B Check One

MEDICAL INTERVENTIONS: If patient is found with a pulse and/or is breathing.

- [ ] Full Treatment**– primary goal of prolonging life by all medically effective means.**
  In addition to treatment described in Selective Treatment and Comfort-Focused Treatment use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
  - [x] Trial Period Of Full Treatment
- [ ] Selective Treatment**– goal of treating medical conditions while avoiding burdensome measures.**
  In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally, avoid intensive care.
  - [x] Request Transfer To Hospital **only if comfort needs cannot be met in current location.**
- [ ] Comfort-Focused Treatment**– primary goal of maximizing comfort.**
  Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. **Request Transfer To Hospital only if comfort needs cannot be met in current location.**

Additional Orders: _____

C Check One

ARTIFICIALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible and desired.

- [ ] Long-Term Artificial Nutrition, including feeding tubes
- [ ] Trial Period Of Artificial Nutrition
- [ ] No Artificial Means Of Nutrition

Additional Orders: _____

D Check One

INFORMATION AND SIGNATURES:

Discussed with:	[x] Patient (Patient Has Capacity)	[ ] Legally Recognized Decisionmaker

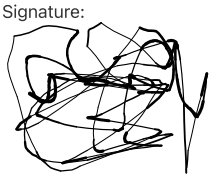
- [x] Advance Directive Dated Date comes here ,available and reviewed ->
- [ ] Advance Directive Not Available
- [ ] No Advance Directive

Healthcare Agent if named in Advance Directive:
Name: Name
Phone: Phone

Signature Physician:
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician Name: physician name	Phone: phone	License #: 445566
Physician Signature:		Date: 2024-06-27

Signature of Patient or Legally Recognized Decisionmaker:
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the patient who is the subject of the form.

Print Name: Name	Relationship (write self if patient): Relationship
Signature: 	Date: Date

Mailing Address (street/city/state/zip): Address	Phone: Phone	Office Use Only: Office Use Only

MEDICATION RECONCILIATION

Phone: 987654321
HICN: 456852
DIAGNOSIS: diagnosis ALLERGIES: allergy
HEIGHT: 5.5 WEIGHT: 50
REVIEWED FOR CONTRAINDICATIONS: ☑ Yes ☐ No
REVIEWED FOR INTERACTIONS: ☑ Yes ☐ No

PHARMACY NAME:pharm name
ADDRESS:pharm address
PHONE:45678165651

Prescribed Medications	DOSE	ROUTE	FREQUENCY	PURPOSE	REFILLS
acefyl	3 times	INH	Topical	QID	3

See Attachment

ASSIGNMENT INSURANCE

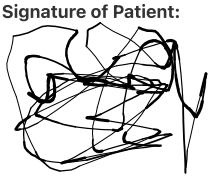
Medicare Certification: I certify that the information provided by me in applying for payment under TITLE XVII of the Social Security Act is correct and request on my behalf all authorized benefits. I hereby authorize and instruct my insurance carrier to make payment directly to Remedial Patients Care, Inc. for benefits (payments) otherwise payable to me. I agree to personally pay for any charge that are not covered by or collected from any insurance program including any deductibles and coinsurance amounts.

I certify that all information given are correct and consent to the release of all records for payment of authorized benefits from Medical, Medicaid, or any other responsible payer be made in my behalf to Remedial Patients Care, Inc.

I understand that the Federal Patient Self -Determination Act of 1990 requires that I be made aware of my right to make healthcare decision for myself. I understand that I may guess express my wishes in a document called an Advance Directives so that my wishes may be known when I am unable to speak for myself.

1. I have a Living Will declarations ☑ Yes ☐ No

   (If yes, please provide a copy of your will.)
2. I have a Durable Power of Attorney for Health Care ☑ Yes ☐ No

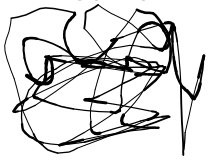
Name of patient: Muhammad Zain	Date of Birth: 1996-07-30
Address: Islamabad Islamabad	
Signature of Patient: 	Date:

LEGAL REPRESENTATIVE (IF PATIENT IS UNABLE TO SIGN)

Consent of Legal Guardian, Patient Advocate or Nearest Relative if patient is unable to sign
Consent of Caregiver if patient is unable to sign (Must have Power of Attorney)

Name of Legal Representative: name of representative				
Relationship: cousin		Telephone: Not present in data		
Address: adress 1 address 2				
Unit: Not present in data	Street: Not present in data	City: isb	State: pa	Zip: Not present in data
Signature of Legal Rep:		Date:		
Name of Witness: Not present in data		witness_signatures Signature:		Date:
Reason patient is unable to sign: Not present in data				

ANNUAL WELLNESS

Current list of patient's providers and suppliers	Name	Speciality	Reason	
	sample name	sample Speciality	sample reason	
Special Diet ☐ Yes ☑ No	Description:	☑ Diabetic	☑ Dash	
Cognitive Impairment	☐ None	☑ Dimentia	☐ Mild Memory Loss	
List of medication, supplement and vitamins	Please see attach			
Depression screening	Felt depressed/hopeless over the last 2 weeks	☑ Yes ☐ No	Evaluation/Referrals: Schedule Appointments:	Notes:
	Little or no pleasure in doing thing over the last 2 weeks	☑ Yes ☐ No	Evaluation/Referrals: referrals Schedule Appointments: appoitments	Notes: notes
Hearing loss screening	Trouble hearing television or radio when others do not	☑ Yes ☐ No	Evaluation/Referrals: Schedule Appointments:	Notes:
	Strain or struggle to hear/understand conversations	☑ Yes ☐ No	Evaluation/Referrals: Schedule Appointments:	Notes:
Home safety screening	Throw rugs, poor lighting or slippery bathtub/shower at home	☑ Yes ☐ No	Evaluation/Referrals: Schedule Appointments:	Notes:
	Lack of grab bars, bathrooms, handrails on stairs and steps at home	☑ Yes ☐ No	Evaluation/Referrals: Schedule Appointments:	Notes:
Fall risk screening	Unsteady or take longer han 30 seconds to get up and go	☑ Yes ☐ No	Evaluation/Referrals: Schedule Appointments:	Notes:
Advance care planning	Patient consent: I consent to discuss end-of- life issues with my healthcare provider	PATIENT SIGNATURE 		
	Patient has already executed an advance directive	☐ Yes ☑ No		
	If no, patient was given an opportunity to execute an Advance Directive	☐ Yes ☑ No		
	Physician statement: "Patient has the ability to prepare an Advance Directive."	YES NO		
	Physician has completed a Order of Life-Sustaining Treatment, or similardocument of another name, reflecting the patient's wishes	☐ Yes ☑ No		
	Physician SIGNATURE	physician_signatures		DATE: 2024-06-27

Preventive screening (frequency) Screened Schedule (5-10 Years)	Coverage		Previously Screening If YES (When)	
Bone mass measurements (every 24 months)	Medicare patients at risk for developing osteoporosis	Previously Screened: ☐ Yes ☑ No	Previously Screened On:	☑ NEEDS
Cardiovascular screening blood tests (every 5 years) <Lipid panels> <Cholesterol> <Lipoprotein> <Triglycerides>	All asymptomatic Medicare patients (12-hour fast is required)	Previously Screened: ☑ Yes ☐ No	Previously Screened On: 2024-06-13	☐ NEEDS

Colorectal cancer screening, flexible sigmoidoscopy (4 years, or once every 10 years after 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; for 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	Previously Screened:	☑ Yes ☐ No	Previously Screened On: 2024-06-03	☐ NEEDS
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 those diagnosed with pre-diabetes (patients previously diagnosed with diabetes aren't eligible)	Previously Screened:	☐ Yes ☑ No	Previously Screened On:	☑ NEEDS
Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (Up to 10 hours of initial training within a continuous12-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)	Previously Screened:	☐ Yes ☑ No	Previously Screened On:	☑ NEEDS
Glaucoma screening (annually for patient in one or more high risk groups)	Patients with diabetes mellitus, family historyor glaucoma, African-Americans age 50 andup, or Hispanic-Americans age 65 and up	Previously Screened:	☐ Yes ☑ No	Previously Screened On:	☑ NEEDS
Prostate cancer screening (annually) Digital rectal exam Prostate-specific antigen test	Male Medicare patients 50 and up	Previously Screened:	☐ Yes ☑ No	Previously Screened On:	☑ NEEDS
Screening PAP tests and pelvic examination (Annually if high-risk, or child bearing age with abnormal PAP test within past 3 years; every 24 months for all other women)	Female Medicare patients	Previously Screened:	☐ Yes ☑ No	Previously Screened On:	☑ NEEDS
Screening mammography (annually)	All female patients 40 or older	Previously Screened:	☐ Yes ☑ No	Previously Screened On:	☑ NEEDS
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 if at least 5 years have passed since previous dose; for hepatitis B, if patient is medium/high risk	Previously Screened:	☐ Yes ☑ No	Previously Screened On:	☑ NEEDS

ENCOUNTER CHECKLIST FOR TOBACCO

PLEASE ADVISE the patient/smoker to stop:
As your healthcare provider, I strongly advise you to quit smoking. It's the single most important thing you can do to protect your health, and I can help.

ASSESS readiness to quit:
Patient Is Ready To Quit Target quit date: .. / .. / ....
Patient Is Thinking About Quitting Brief Counseling Using 5 R's

Name: Muhammad Zain
DOB: 1996-07-30
Encounter Dates: .. / .. / .....
Visit # 1 2 3 4

Relevant Reasons: ..... reasons .....
Risks: ..... risks .....
Rewards: ..... rewards .....
Quit smoking < ..... years ago
Smoked for ..... years.
Patient Is Not Ready To Quit Repetition Relapse

ASSIST smoker to quit:
Smoking history: ..... # of Cigarettes/Day ..... # of Packs/Day ..... # of Years ..... # of Quit Attempts
Household members: ..... # of Smokers ..... # of Non-smokers ..... # of Children

SYMPTOMS:
☑ Abnormal Sputum ☐ Dyspnea ☐ Cough ☐ Diminished Air Movement ☐ Hemoptysis ☑ Wheeze ☐ Asthma

MEDICATIONS:
Nicotine replacement therapy: ☑ Nasal Spray ☑ Lozenge ☐ Inhaler ☐ Patch ☐ Gum
Bupropion SR: Tablets (Start 7 To 10 Days Before The Target Quit Date.)

ARRANGE Follow-up:
"I'll Check Back With You By (.. / .. / ....)." (Set Within The First Week After The Target Quitdate)
"I'd Like To Give You Some Materials."

Printed Name ...name... **Signature** ...signature... **Date** .. / .. / ....

FALL RISK CHECK-LIST

		Circle "Yes" or "No" for each statement below	Why it matters
☐ Yes	☑ No	I often feel sad or depressed.	Symptoms of depression, such as not feeling well or feeling slowed down, are linked to falls.
☐ Yes	☑ No	I take medicine to help me sleep or improve my mood.	These medicines can sometimes increase your chance of falling.
☐ Yes	☑ No	Sometimes I feel unsteady when I am walking	Unsteadiness or needing support while walking are signs or poor balance.
☐ Yes	☑ No	I need to push with my hands to stand up from a chair	This is a sign or weak leg muscles, a major reason for falling
☐ Yes	☑ No	I steady myself by holding onto furniture when walking at home.	This is also a sign of poor balance.
☑ Yes	☐ No	I am worried about falling.	People who are worried about falling are more likely to fall.
☑ Yes	☐ No	I take medicine that sometimes makes me feel light-headed or more tired than usual.	Side effects from medicines can sometimes increase your chance of falling.
☐ Yes	☑ No	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	☐ No	I have fallen in the past year.	People who have fallen once are likely to fall again.
☐ Yes	☑ No	I sometimes have troubles stepping up onto a curb.	This is also a sign or weak leg muscles.
☐ Yes	☑ No	I have lost some feeling in my feet.	Numbness in your feet can cause stumbles and lead to falls.
☐ Yes	☑ No	I often have to rush to the toilet.	Rushing to the bathroom, especially at night, increase your chance of falling

Total 3 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 check list with your doctor.

This checklist was developed by the Greater Los Angeles VA Geriatric Research Education Clinical Center and affiliates and is a validated fall risk self-assessment too (Rubenstein at al. J Safety Res; 2011:42(6)493-499). Adapted with permission of the authors.

Signature .....signature.....
Name of Provider .. name of provider ..
Date: ../../....

RECORDS RELEASE

RECORDS REQUESTED

- **The patient's significant medical history**
- **Current medical findings**
- **Diagnosis (es)**
- **Rehabilitation goals, if determined**

Name of Patient: Muhammad Zain. Medicare No: ..1231233..
Social Security No: ..12123131313.. Date of Birth: 1996-07-30
Address: .....,.....,.....
City: ...city... **State: ...state...** **Zip: ..zip..**

AUTHORIZATION SIGNATURE **.....signature.....** DATE: .

NAME OF SIGNATORY:
(IF DIFFERENT FROM PATIENT)
Relationship to patient:
Witness ....witness.... Date

THIS RELEASE IS VALID FOR 6 MONTHS FROM THE DATE OF SIGNATURE.