



This is the original report for comparison purposes.

Note:

- 1. Margin at top is small
- 2. Header is sans-serif
- 3. Font size is probably 10 or 11 – fairly small.

# Annual Personalized Wellness Plan

Patient Name: Willy Doe MRN: 123456789A  
Date: May 23, 2017 Practice: New River Family Medicine  
Healthcare Provider: Karen A Williams 1300 St Marys Street Suite 502 R

Your personalized Wellness Plan is based on risk factors identified during your Annual Wellness Visit. Work with your doctor to complete each of the identified screenings and recommended counseling over the next 12 months to ensure you stay as healthy as possible. Speak with your Doctor if you have any questions about this plan.

## Your Key Vital Signs

Age: 86 Blood Pressure: 137 / 88  
Weight: 190 lbs. Weight Analysis:  
Height: 5' 9" (69 inches)  
Body Mass Index (BMI): 28 Weight Loss Counseling:

Medicare Recommended Preventive Services		Code	Your Benefit / Guidelines	Needed this year*		
Immunizations / Vaccinations	Pneumonia	G0009	1 dose age 65+	Yes	<input type="checkbox"/>	No <input checked="" type="checkbox"/>
	Influenza	G0008	Annually	Yes	<input checked="" type="checkbox"/>	No <input type="checkbox"/>
	Shingles	90736/90471	As needed, if at risk	Yes	<input type="checkbox"/>	No <input checked="" type="checkbox"/>
Diabetes Screening	Blood test	82947	w/ Sustained BP >= 135/80	Yes	<input checked="" type="checkbox"/>	No <input type="checkbox"/>
Cholesterol Testing	Blood test	82465	As needed w/ risk factors	Yes	<input checked="" type="checkbox"/>	No <input type="checkbox"/>
Vision / Glaucoma Screening	Eye test	G0117/G0118	Every 2 years - age 40+	Yes	<input type="checkbox"/>	No <input checked="" type="checkbox"/>
Sexually Transmitted Disease/HIV	Blood test	G0475	As needed per risk	Yes	<input checked="" type="checkbox"/>	No <input type="checkbox"/>
Osteoporosis	Bone Density	76977	Routine	Yes	<input type="checkbox"/>	No <input checked="" type="checkbox"/>
Colorectal Cancer Screening	Fecal Blood	G0328	Annually	Yes	<input checked="" type="checkbox"/>	No <input type="checkbox"/>
	Sigmoidoscopy	G0104	Every 5 years	Yes	<input type="checkbox"/>	No <input checked="" type="checkbox"/>
	Colonoscopy	G0121	Every 10 years	Yes	<input type="checkbox"/>	No <input checked="" type="checkbox"/>
Breast Cancer Screening	Mammogram	G0202	Female, Every 2 years	Yes	<input type="checkbox"/>	No <input checked="" type="checkbox"/>
Prostate Cancer Screening	PSA	G0103	Male, Annually	Yes	<input checked="" type="checkbox"/>	No <input type="checkbox"/>

## Social/Behavioral Screenings

Smoking / Tobacco Use	Counseling	99406/99407	As needed, if at risk	Yes	<input checked="" type="checkbox"/>	No <input type="checkbox"/>
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This is your  
first  
attempt...

You did a  
good job  
making the  
gutters  
smaller and  
changing the  
body font to  
sans serif.

Patient Name: Today 5Dec

Date: May 28, 2024

Healthcare Provider: Karen A Williams, RN

MRN: 123456789

Practice: New River Family Medicine  
1300 St Mary's Street Suite 502 R

Your personalized Wellness Plan is based on risk factors identified during your Annual Wellness Visit. Work with your doctor to complete each of the identified screenings and recommended counseling over the next 12 months to ensure you stay as healthy as possible. Speak with your Doctor if you have any questions about this plan.

#### Your Key Vital Signs

Age:	67	Blood Pressure:	N/A
Weight:	N/A		
Height:	N/A		
Body Mass Index (BMI):	N/A		

Medicare Recommended	Preventive Services	Code	Your Benefit/Guidelines	Needed	This year*
Immunizations/Vaccines	Pneumonia	G0009	1 dose age 65+	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Immunizations/Vaccines	Influenza	G0008	Annually	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Immunizations/Vaccines	Shingles	90736	As needed, if at risk	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Diabetes Screening	Blood test	82947	w/ sustained B/P >= 130/80	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Cholesterol Testing	Blood test	82465	As needed w/ risk factors	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Vision/Glaucoma Screening	Eye test	G0117	Every 2 years, age 40+	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Sexually Transmitted Disease/HIV	Blood test	G0475	As needed per risk	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Osteoporosis	Bone density	76977	Routine	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Colorectal Cancer Screening	Colonoscopy	G0121	Every 5-10 years	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Breast Cancer Screening	Mammogram	G0202	Female, every 2 years	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Prostate Cancer Screening	PSA	G0103	Male, annually	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

#### Social/Behavioral Screenings

Smoking/Tobacco Use	Counseling	99406	As needed, if at risk	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Alcohol Misuse Screening	Counseling	G0442	As needed, if at risk	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Substance Abuse Screening	Counseling	G0396	As needed, if at risk	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Cognitive Impairment Screening	Testing	96103	As needed, if at risk	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Depression Screening	Counseling	G0444	As needed, if at risk	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

#### Your Additional Risk Factors

Weight/BMI	Counseling	G0447	As needed, if BMI out of limits	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Fall Risk/Mobility	Assessment	92541	As needed, if at risk	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Physical Activity/Exercise	Counseling	Varies	As needed, if at risk	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
Nutrition/Diet	Counseling	G0270	As needed, if at risk	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

This is your second attempt... MUCH Improved!

**But** it now prints on 1 ½ pages instead of 1 page. I think that if you do these three things it will help get it to a single page:

1. Decrease the margin on the top. Look at the original to see.
2. Change the header “Annual Personalized Wellness Plan” to a sans-serif font like the rest of the report.
3. Change the overall font size to one that is 2 points smaller.

## Annual Personalized Wellness Plan

Patient Name: **Sourav Ganguly**  
Date: **June 02, 2024**  
Healthcare Provider: **Daniel Jacobi**

MRN: **MRN2003**  
Practice: **New River Family Medicine**  
1300 St Marys Street Suite 502 R

*Your personalized Wellness Plan is based on risk factors identified during your Annual Wellness Visit. Work with your doctor to complete each of the identified screenings and recommended counseling over the next 12 months to ensure you stay as healthy as possible. Speak with your Doctor if you have any questions about this plan.*

### Your Key Vital Signs

Age:	<u>41</u>	Blood Pressure:	<u>150 /50</u>
Weight:	<u>200 lbs.</u>		
Height:	<u>66 inches</u>		
Body Mass Index (BMI):	<u>32</u>		

Medicare Recommended	Preventive Services	Code	Your Benefit/Guidelines	Needed This year*	
Immunizations/Vaccines	Pneumonia	G0009	1 dose age 65+	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Immunizations/Vaccines	Influenza	G0008	Annually	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Immunizations/Vaccines	Shingles	90736	As needed, if at risk	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Diabetes Screening	Blood test	82947	w/ sustained B/P >= 130/80	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Cholesterol Testing	Blood test	82465	As needed w/ risk factors	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Vision/Glaucoma Screening	Eye test	G0117	Every 2 years, age 40+	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Sexually Transmitted Disease/HIV	Blood test	G0475	As needed per risk	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Osteoporosis	Bone density	76977	Routine	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Colorectal Cancer Screening	Colonoscopy	G0121	Every 5-10 years	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Breast Cancer Screening	Mammogram	G0202	Female, every 2 years	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Prostate Cancer Screening	PSA	G0103	Male, annually	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>

### Social/Behavioral Screenings

Smoking/Tobacco Use	Counseling	99406	As needed, if at risk	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>
Alcohol Misuse Screening	Counseling	G0442	As needed, if at risk	Yes <input checked="" type="checkbox"/>	No <input type="checkbox"/>

# General Remarks

- Needs to print on 1 page
- Decrease margin at top slightly to give it more room
- Header needs to be sans serif font
- Decrease body font by 1-2 points to see if that makes it print on a single page
- GOOD job on getting the columns to line up!
- We are VERY close!