

Hello!

**The attached forms are provided for patients scheduled for a Medicare Annual Wellness Visit in our office.** You may download and complete these forms prior to your scheduled visit.

If you prefer, we are happy to provide you a copy of these forms when you arrive. Please arrive at least 20 minutes prior to your scheduled appointment to allow time to complete your forms.

If you choose to print or download these forms now, please note the following:

- Medicare Health Risk Assessment—**REQUIRED**
- Advance Directive—**NOT REQUIRED**  
*(If you choose to complete your Advance Directive, we are happy to notarize it for you at our office. You may elect not to complete an Advance Directive if you wish not to have one or if you have already completed one.)*

We look forward to seeing you!

# Medicare Health Risk Assessment



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

<b>BEHAVIORAL RISK FACTORS</b>					
Smoking Tobacco Use: Do you currently smoke cigarettes or use other types of tobacco? (Choose one)					
<input type="checkbox"/> None	<input type="checkbox"/> Occasional	<input type="checkbox"/> Daily	<input type="checkbox"/> Prior use		
Alcohol Use: In a typical week, how many days do you drink alcohol?					
<input type="checkbox"/> None	<input type="checkbox"/> Occasional	<input type="checkbox"/> Daily	<input type="checkbox"/> Prior use		
Illicit Drug Use:					
<input type="checkbox"/> None	<input type="checkbox"/> Occasional	<input type="checkbox"/> Daily	<input type="checkbox"/> Prior use		
<b>DIET</b> Are you on a special diet? <input type="checkbox"/> Yes <input type="checkbox"/> No Comments: _____					
<b>SELF ASSESSMENT OF HEALTH STATUS</b>					
General Well-Being: In general, would you say that your health is:					
<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	
Exercise: How intense is your typical exercise? (choose one)					
<input type="checkbox"/> Light (stretching or slow walking)	<input type="checkbox"/> Moderate (brisk walking)	<input type="checkbox"/> Heavy (jogging or swimming)	<input type="checkbox"/> Very Heavy (fast running)	<input type="checkbox"/> I am currently not exercising	
<b>PSYCHOLOGICAL RISK FACTORS</b>					
<b>Over the last 7 days have you been bothered by any of the following problems?</b>					
		Not at all	Several days	More than half the days	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
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 family down	0	1	2	3
7	Trouble concentrating on things such as reading the newspaper or watching TV	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
<b>FUNCTIONAL ABILITY AND LEVEL OF SAFETY</b>			<b>HOME SAFETY</b>		
Do you need help from others to perform everyday activities such as:			Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Eating	<input type="checkbox"/> Yes <input type="checkbox"/> No		Does your home have any of the following?		
Getting Dressed	<input type="checkbox"/> Yes <input type="checkbox"/> No		Throw Rugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Grooming	<input type="checkbox"/> Yes <input type="checkbox"/> No		Poor Lighting	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bathing	<input type="checkbox"/> Yes <input type="checkbox"/> No		Slippery bathtub or shower	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Walking	<input type="checkbox"/> Yes <input type="checkbox"/> No		Does your home lack any of the following?		
Using the toilet	<input type="checkbox"/> Yes <input type="checkbox"/> No		Grab Bars in Bathrooms	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you need help from others to take care of such things as:			Handrails on Stairs or Steps	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Laundry	<input type="checkbox"/> Yes <input type="checkbox"/> No		Functioning Smoke Alarms	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Housekeeping	<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>FALL RISK</b>		
Shopping	<input type="checkbox"/> Yes <input type="checkbox"/> No		Have you had two or more falls in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Banking	<input type="checkbox"/> Yes <input type="checkbox"/> No		Any fall with injury in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Transportation	<input type="checkbox"/> Yes <input type="checkbox"/> No		Are you worried about falling or feel unsteady when standing or walking? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Taking Medicine	<input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have urinary leakage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Preparing Meals	<input type="checkbox"/> Yes <input type="checkbox"/> No		<b>ADVANCED CARE PLANNING</b>		
Using the Telephone	<input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have an Advance Directive (Living Will)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>HEARING LOSS SCREENING</b>					
Do you have trouble hearing the television or radio when others do not? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you have to strain or struggle to hear/understand conversations? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## ADVANCE DIRECTIVE

An advance directive is a document that allows a principal to select someone else to make health care decisions if they are not able to for themselves. In addition, it will enable a principal to choose their end-of-life treatment options on whether to prolong their life. Depending on State law, this document must be signed in the presence of a notary public and/or two ( 2) witnesses.

**THIS FORM CONTAINS 2 PARTS** (EACH PART IS OPTIONAL):

PART I. MEDICAL POWER OF ATTORNEY

PART II. LIVING WILL

### PART I. MEDICAL POWER OF ATTORNEY

A medical power of attorney allows you the right to name someone else to make health care decisions on your behalf

I choose to: (initial and check) (choose one)

\_\_\_\_\_  - Have a medical power of attorney

\_\_\_\_\_  - Not have a medical power of attorney Part I of this form is intentionally left blank.

**A. PRINCIPAL.** I, \_\_\_\_\_, with a mailing address of \_\_\_\_\_, City of \_\_\_\_\_, State of \_\_\_\_\_, Zip Code \_\_\_\_\_

("Principal") hereby designate:

**B. AGENT.** \_\_\_\_\_, with a mailing address of \_\_\_\_\_, City of \_\_\_\_\_, State of \_\_\_\_\_, Zip Code \_\_\_\_\_ ("Agent").

AGENT'S TELEPHONE (CELL) ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

I select the above-named person as my Agent to act in all matters relating to my health care (including my mental health care) and including, without limitation, the power to give or refuse consent to all medical and surgical treatments, hospitalizations, and all related health care. This power of attorney is effective at the point when I am no longer able to communicate my health care wishes. My Agent's decisions under this power of attorney, during any period when I am unable to make and/or

communicate my health care decisions or when there is uncertainty as to whether I am dead or alive, are binding on my heirs, devisees, and personal representatives.

**C. ALTERNATE AGENT.** If my Agent is unable or unwilling to serve or make a decision in a timely manner, I select \_\_\_\_\_, with a mailing address of \_\_\_\_\_, City of \_\_\_\_\_, State of \_\_\_\_\_, Zip Code \_\_\_\_\_ to act as my alternate agent (“Alternate Agent”)

ALTERNATE AGENT S TELEPHONE (CELL): (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

I intend for my Agent to receive any and all of my health records and information as if I were the one requesting such information This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (aka HIPAA), 42 USC 14200, and 45 CFR 160-164.

## PART II. LIVING WILL

A living will allows a principal to select end-of-life treatment options in the chance of incapacitation with no viable cure.

I choose to: (initial and check) (choose one)

\_\_\_\_\_  - Have a living will.

\_\_\_\_\_  - Not have a living will. Part II of this form is intentionally left blank.

**A. PRINCIPAL.** I, \_\_\_\_\_, with a mailing address of \_\_\_\_\_, City of \_\_\_\_\_, State of \_\_\_\_\_, Zip Code \_\_\_\_\_, with the last four (4) digits of my social security number (SSN) being XX- XXX - \_\_\_\_\_ (“Principal”) desire to advise my doctors and medical providers of my wishes for my health care in the event I am not able to communicate my wishes.

### B. LIFE SUPPORT.

I desire that my doctor make a concerted effort to return me to an acceptable quality of life using then available treatments and therapies. However, if my quality of life becomes unacceptable as I have defined below, and my doctors have determined that my condition will not improve (is irreversible), I direct that all treatments that extend my life be withdrawn.

An unacceptable quality of life means (initial and check all that apply):

\_\_\_\_\_  - Chronic coma or persistent vegetative state

- \_\_\_\_\_  - No longer able to communicate my needs
- \_\_\_\_\_  - No longer able to recognize family and friends
- \_\_\_\_\_  - Total dependence on others for daily care
- \_\_\_\_\_  - Other: \_\_\_\_\_

(initial and check) (choose one)

\_\_\_\_\_  - Even if I have the quality of life described above, I still wish to be treated with food and water by tube or intravenously (IV)

\_\_\_\_\_  - If I have the quality of life described above, I do NOT wish to be treated with food and water by tube or intravenously (IV).

**C. CERTAIN LIFE-SUSTAINING TREATMENT.**

Some people do not wish to have certain life-sustaining treatments under any circumstance, even if recovery is a possibility. Check the treatments below, if any, that you do not wish to have under any circumstances.

(initial and check) (choose one):

- \_\_\_\_\_  - Cardiopulmonary Resuscitation (CPR)
- \_\_\_\_\_  - Ventilation (breathing machine)
- \_\_\_\_\_  - Feeding tube
- \_\_\_\_\_  - Dialysis
- \_\_\_\_\_  - Other: \_\_\_\_\_

**A. END OF LIFE WISHES (hospice care, funeral arrangements, etc.):**

When I am near death, it is important to me that \_\_\_\_\_  
 \_\_\_\_\_

I have signed this document on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Principal's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Depending on your State's laws, you either need two (2) witnesses and/or notary public may be required for signing this form.

**WITNESSES/NOTARY ACKNOWLEDGEMENT**

On this date set forth above, I hereby state as follows:

The above-named person is personally known to me, and I believe him/her to be of sound mind and to have voluntarily executed this document. I am not an Agent or successor Agent named in this document. To my knowledge, I am not a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

**WITNESS 1**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

**WITNESS 2**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

**NOTARY ACKNOWLEDGEMENT**

State of \_\_\_\_\_ }

County of \_\_\_\_\_ }

Signed and sworn to me on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

I, the undersigned authority in and for said County in said State, hereby certify that the Principal, \_\_\_\_\_, whose name is signed above in this living will, and who is known to me, acknowledged before me on this day that, being informed of the contents of the said document, (s)he executed the same voluntarily on the day the same bears date.

Given under my hand this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Notary Public Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

My commission expires: \_\_\_\_\_