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Name:				ID:	Form Date:
Admitted:					Unit:
Gender: Female	-	hdate:		<u>Aae</u> :	
See continua	ion sheet?	☐ Yes	□ No		
other Relevar	t Findings:				
Notes and Pla	ın:				
See continua	ion sheet?	D Yes	🗆 No		
Provider Sign	ature:				Date:
Schedule of F	ersonalized He	ealth Plan (P	rovide Copy te	o Patient)	
Service	Date of	Most Recent	Service		Date Scheduled
Vaccines: Pn	eumococcal (O	nce after 65)	. Influenza	a (Annually) Hepatiti	s B (if medium/high risk)
Medicare Cov	erage Require	ments:			
Medium/ high	risk factors: Er	nd stage rena	al disease. He	emophiliacs who rec	eived Factor VIII or IX concentrates. Clients of institutions for the
mentally retar	ded. Persons w	vho live int e	h same house	e as a HepB virus ca	rrier. Homosexual men illicit injectable drug abusers
Provider Reco	ommendation:				
Service	Date of	Most Recent	t Service		Date Scheduled
Mammogram	(biennial age 5	0-74)			
Medicare Cov	erage Require	ments:			
Annually (age	40 or over)				
Provider Reco	ommendation:				
Service	Date of	Most Recent	t Service		Date Scheduled
Pap and pelv	c exams (up to	age 70 and	after 70 if unk	known history or abr	normal study last 10 years)
Medicare Cov	erage Require	ments:			
Every 24 mor	ths except high	n risk			
Provider Reco	ommendation:				
Service	Date of	Most Recent	Service		Date Scheduled
Prostate cano	er screening (a	innually to a	ge 75) Digital	rectal exam (DRE) I	Prostate specific antigen
Medicare Cov	erage Require	ments:			
Annually (age	50 or over), D	RE not paid	separately w	hen covered E/M se	rvice is provided on same date
Provider Reco	ommendation:				
Service	Date of	Most Recent	Service		Date Scheduled
Colorectal ca	ncer screening	(to age 75).	Fecal occult b	blood test (annual). I	Flexible sigmoidoscopy (Sy). Screening colonoscopy (10y). Barium e
Medicare Cov	erage Require	ments:			

Roland Park Place

Page 4 03/19/19 12:51 Annual Wellness Exam ID: Name: Form Date: HI Unit: Admitted: Gender: Birthdate: Age: Service Date of Most Recent Service Date Scheduled Diabetes self- management training (no USPSTF recommendation) Medicare Coverage Requirements: Requires referral by treating physician for patient with diabetes or renal disease. 10 hours of initial DSMT sessions of no less than 30 minutes each in a continuous 12-month period. 2 hours of follow-up DSMT in subsequent years. Provider Recommendation: Service Date of Most Recent Service Date Scheduled Bone mass measurements (age 65 & older, biennial) Medicare Coverage Requirements: Requires diagnosis related to osteoporosis or estrogen deficiency. Biennial benefit unless patient has history of long term glucocorticoid use or baseline is needed. Provider Recommendation: Date of Most Recent Service Date Scheduled Service Glaucoma screening (no USPSTF recommendation) Medicare Coverage Requirements: Diabetes mellitus, family history African American, age 50 or over, Hispanic American age 65 or over Provider Recommendation Service Date of Most Recent Service Date Scheduled Medical nutrition therapy for diabetes or renal disease (no recommended schedule) Medicare Coverage Requirements: Requires referral by treating physician for patient with diabetes or renal disease. Can be provided in same year as diabetes self-management training (DSMT), and CMS recommends medical nutritional therapy take place after DSMT, Up to 3 hours for initial year and 2 hours in subsequent years Provider Recommendation: Service Date of Most Recent Service Date Scheduled Cardiovascular screening blood tests (every 5 years) Total Cholesterol, High-density lipoproteins, Triglycerides Medicare Coverage Requirements: Provider Recommendation: Service Date of Most Recent Service Date Scheduled Diabetes screening test (at least every 3 years Medicare covers annually or at 6month intervals for pre-diabetic patients). Fasting blood sugar (FBS) or glucose tolerance test (GTT)

Medicare Coverage Requirements:

Patient must be diagnosed with one of the following: Hyper Tension, Dyslipidemia, Obesity (BMI > 30kg/m2) Previous elevated impaired FBS or GTT or any two of the following: Over weight (BMI >25 but <30) Family History, Age 65 years or older, History of gastrointestinal diabetes or birth of baby weighing more than 9 pounds

Roland Park Place Page 5 03/19/19 12:51 Annual Wellness Exam Form Date: Name: ID: Admitted: Unit: Gender: Birthdate: Age: Provider Recommendation: Date of Most Recent Service Date Scheduled Service Abdominal aortic aneurysm screening (once) Medicare Coverage Requirements: Patient must be referred through IPPE and not have had a screening for abdominal aortic aneurysm before under Medicare. Limited to patients who meet one of the following criteria: Men who are 65-75 years old and have smoked more than 100 cigarettes in their lifetime. Anyone with a family history of aortic aneurysm. Anyone recommended for screening by the USPSTF Provider Recommendation: Service Date of Most Recent Service **Date Scheduled** HIV screening (annually for increased risk patients) HIV-1 and HIV-2 by EIA, ELSIA, rapid antibody test or oral mucosa transudate. Medicare Coverage Requirements: Patient must be at increased risk for HIV infect per USPSTF guidelines or pregnant. Test covered annually for patients at increased risk. Pregnant patients may receive up to 3 tests during pregnancy. Provider Recommendation: Service Date of Most Recent Service **Date Scheduled** Smoking cessation counseling (up to 8 sessions per year) Counseling greater than 3 and up to 10 minutes. Counseling greater than 3 and up to 10 minutes. Counseling greater than 10 minutes Medicare Coverage Requirements: Patients must be a smoker Provider Recommendation: Service Date of Most Recent Service Date Scheduled Subsequent annual wellness visit Medicare Coverage Requirements: At least 12 months since IPPE or AWV Provider Recommendation: Date of Most Recent Service **Date Scheduled** Service Other based on patient's risk factors Medicare Coverage Requirements: Provider Recommendation: Date of Most Recent Service Date Scheduled Service Other based on patient's risk factors: Medicare Coverage Requirements: Provider Recommendation:

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Annual Wellness Exam

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	Name:		ID:	Form Dat	e:	
	Admitted:			Unit:		
	Gender:	Birthdate:	Age:			
	Service	Date of Most Recent Service		Date Scheduled		
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	Medicare Cov	erage Requirements:				
	Provider Reco	ommendation:				
	Service	Date of Most Recent Service		Date Scheduled		
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