North Charlotte Medical Specialists

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I would like to welcome you to North Charlotte Medical Specialists-University for your "Annual Wellness Visit" (also known as AWV) with Medicare insurance.

We have your appointment scheduled for

_____ with Dr._____

We need you to complete 2 enclosed forms ***PRIOR*** to arriving to the office for your appointment:

1. Patient History Form
2. Functional Abilities/Depression Questionnaire.

Please bring these 2 ***completed*** forms to your visit along with your Medicare card.

We have also enclosed an information sheet called "Medicare Preventive Services." This explains each individual preventive service, who is covered for these services, and the frequency allowed, now that you are covered by Medicare insurance.

Thank you for choosing North Charlotte Medical Specialists-University as your Primary Care Provider and Medical Home.

Sincerely,

Tina Bostic
Practice Manager

WELCOME TO MEDICARE VISIT

This is a one-time benefit during the 1st year of Medicare coverage. It is a review and consultation visit only, and *does not include a routine full physical exam.*

Prior to arrival for the visit, information forms required by Medicare must be completed and include a patient history form, depression screen and functional abilities questionnaire.

The visit consists of review of your pre-completed information forms, vital signs measurement, visual acuity testing, and a written checklist for education, counseling and referral for tests and services covered under the Medicare preventive benefits.

At the end of the visit, a written summary will be given and any needed tests can be scheduled.

A routine full physical examination is *not* a covered benefit under Medicare but can be scheduled for a different time.

Evaluation of any problem or followup for any chronic illnesses will need to be scheduled for a different visit. This will ensure sufficient time to discuss services available to promote your health.

Patients requesting this visit may call to schedule and will be mailed the forms for completion prior to the visit.

ANNUAL WELLNESS VISIT

Beginning in 2011, Medicare will cover an annual wellness visit. This can only be done after the 1st year of Medicare eligibility, and must not be done within 12 months of having received the initial "Welcome to Medicare Visit".

Similar to the initial "Welcome" visit, it includes a health risk assessment and a personalized prevention plan with development of a yearly schedule for appropriate preventive services. The visit *does not include a routine full physical exam.*

Required elements are a review of medical and family history, prescribed medication review, listing of all physician providers, measurement of vital signs, observation for detection of cognitive impairment, screening for depression and a functional ability assessment.

Also included is a delineation of risk factors with plans for intervention and referral for health education or preventive services.

This is *not* meant to take the place of a routine physical exam, and followup for management of chronic problems will be done at a separate visit. This will ensure sufficient time to discuss services available to promote your health.

CHS-406 (12/10)

MEDICARE PREVENTIVE SERVICES

WELCOME TO MEDICARE VISIT & ANNUAL WELLNESS VISIT

Carolinas HealthCare System

Uncompromising Excellence. Commitment to Care.

MEDICARE PREVENTIVE SERVICES*

PREVENTIVE SERVICE	WHO IS COVERED	FREQUENCY	BENEFICIARY PAYS
Welcome to Medicare Visit	1st Medicare year	Once	No copayment / no deductible
Annual Wellness Visit – 1st	After 1st Medicare year and not within 12 months of Welcome Visit	Once	No copayment / no deductible
Annual Wellness Visit -subsequent	More than 12 months after 1st Annual Wellness Visit	Annually	No copayment / no deductible
Cardiovascular Screening (lipid test)	All	Every 5 years	No copayment / no deductible
Diabetes Screening (fasting glucose)	Those with risk for diabetes	Annually	No copayment / no deductible
Screening Gynecologic Exam	All females	Every 24 months	No copayment / no deductible
Screening Mammography	All females 40 and older	Annually	No copayment / no deductible
Bone Mass Measurement	All at risk for osteoporosis	Every 24 months	No copayment/ no deductible
Colorectal Cancer Screening (colonoscopy)	Age 50 and older	Every 10 years	No copayment / no deductible
Prostate Cancer Screening (PSA test)	Males 50 and older	Annually	No copayment / no deductible
Ultrasound Screening for Abdominal Aortic Aneurysm	Male current or former smokers age 65-75	Once	No copayment / no deductible
Seasonal Influenza Vaccine	All	Annually	No copayment / no deductible
Pneumococcal Vaccine	All	Once	No copayment / no deductible

*Adapted from "Quick Reference Information: Medicare Preventive Services", published by Medicare Learning Network (official CMS information for fee for service physicians, Centers for Medicare & Medicaid Services). Please see http://www.cms.gov/MLNProducts/downloads/MPS_QuickReferenceChart_1.pdf for a complete listing.

Patient Name_____ Age _____ Date of Birth _____/_____/_____ MRN #_____

As part of your Medicare **Annual Wellness Visit,** please complete the following questionnaire to the best of your ability. It is an important and confidential part of your medical record.

Please list all of your Medical Providers and Suppliers involved in your care:

Please List All Current Medications and Supplements (include over-the-counter & prescription medicine)**:**

Please list any hospitalizations or surgeries you have undergone and the year performed:

Hospitalization / Surgery	**Year**

Do you smoke cigarettes?
☐ No ☐ Yes; how many packs per day? ___

Do you drink alcohol?
☐ No ☐ Yes; how many drinks per day? ___

Have you used drugs for recreation?
☐ No ☐ Yes; what type and when?

Have you or others in your immediate family (parents, grandparents, brothers, sisters, children or grandchildren) had any of the following? (Please check all that apply.)

	Self	Family Member (list relation)		Self	Family Member (list relation)		Self	Family Member (list relation)
General:			**Respiratory:**			**Neurologic:**		
Cancer: Breast	☐	☐	Asthma	☐	☐	Nerve Impairment	☐	☐
Cancer: Colon	☐	☐	Lung disease	☐	☐	Seizure disorder	☐	☐
Cancer: _____	☐	☐	Tuberculosis	☐	☐	Stroke	☐	☐
Weight loss/gain	☐	☐	Pneumonia	☐	☐		☐	☐
	☐	☐	Pleurisy	☐	☐	**Psychiatric:**		
Head:				☐	☐	Alcoholism	☐	☐
Trauma	☐	☐	**Gastrointestinal:**			Anxiety	☐	☐
Concussion	☐	☐	Colitis	☐	☐	Depression	☐	☐
	☐	☐	Diverticulitis	☐	☐	Mental illness	☐	☐
Eyes:			GERD	☐	☐	Phobias	☐	☐
Glaucoma	☐	☐	GI Bleed	☐	☐		☐	☐
Macular degeneration	☐	☐	Liver disease	☐	☐	**Endocrine:**		
	☐	☐	Stomach Ulcer	☐	☐	Diabetes	☐	☐
Ears, Nose, Mouth & Throat				☐	☐	Thyroid disease	☐	☐
Hearing loss	☐	☐	**Genitourinary:**				☐	☐
Vertigo	☐	☐	Enlarged Prostate	☐	☐	**Hematologic:**		
	☐	☐	Kidney Disease	☐	☐	Anemia	☐	☐
Cardiovascular:			Urinary Infection	☐	☐	Blood disorder	☐	☐
Congestive Heart Failure	☐	☐		☐	☐	**Immunologic:**		
Coronary Artery Disease	☐	☐	**Musculoskeletal:**			HIV	☐	☐
Heart disease	☐	☐	Arthritis	☐	☐	**Please list any other condition below:**		
High cholesterol	☐	☐	Fracture	☐	☐		☐	☐
Hypertension	☐	☐	Osteoporosis	☐	☐		☐	☐
Heart murmur	☐	☐					☐	☐
Heart arrhythmia	☐	☐	**Skin:**	☐	☐		☐	☐
Vascular disease	☐	☐	Eczema	☐	☐		☐	☐
	☐	☐	Psoriasis	☐	☐		☐	☐

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status.

Functional Abilities / Depression Questionnaire

Patient Name: _____ **Date:** _____

Functional Abilities Assessment: Please indicate (✓) if you require assistance with any of the following activities.

[ ] Eating
[ ] Bathing
[ ] Dressing
[ ] Grooming
[ ] Going to the toilet
[ ] Preparing meals
[ ] Housework
[ ] Shopping
[ ] Climbing stairs
[ ] Communicating with others
[ ] Moving in and out of bed or chairs
[ ] Following a prescribed drug regimen
[ ] Driving or accessing transportation services

Please select (✓) the best answer for each of the following questions about home safety.

Yes	No	
		Do you have any hearing difficulty or require hearing aid(s)?
		Are lamp, extension and telephone cords placed out of the flow of traffic?
		Are cords in good condition, out from under rugs and furniture?
		Do extension cords always carry their proper load?
		Are all small rugs and runners slip resistant?
		Are emergency numbers posted on or near telephones?
		Could you access a telephone should you experience a fall that prevents you from standing?
		Are all smoke detectors properly placed and in good working order?
		Are all small stoves and heaters placed where they cannot be knocked over and away from furnishings (furniture, curtains, rugs, etc.)?
		Is wood burning equipment installed properly?
		Do you have an emergency exit plan and alternate exit plan in case of fire?
		Are towels, curtains, and other things that might catch fire located away from the range?

Yes	No	
		Are all extension cords and appliance cords located away from the sink or range areas?
		Are hallways, passageways between rooms, and other heavy traffic areas well lit?
		Are exits and passageways kept clear?
		Are bathtubs and showers equipped with non-skid mats, abrasive strips, or surfaces that are not slippery?
		Do bathtubs and showers have at least one (preferably two) grab bars?
		Are all medicines stored in the containers that they came in and are they clearly marked?
		Is a lamp or light switch within reach of your bed?
		Are ash trays, smoking materials or other fire sources (heaters, hot plates, teapots, etc.) located away from beds or bedding?
		Are heating pads always turned off before going to sleep?
		Is there a telephone close to your bed?
		Are stairs well lighted?
		Do the stair steps allow for secure footing?

Depression Assessment: For each of the following questions, please select (✓) the answer that best represents how you have felt over the past week.

Yes	No	
		Have you dropped many of your activities of interest
		Do you feel that your life is empty?
		Do you often get bored?
		Are you afraid that something bad is going to happen to you?
		Do you often feel helpless?
		Do you prefer to stay home, rather than going out and doing new things?
		Do you feel you have more problems with memory than most?
		Do you feel pretty worthless the way you are right now?

Yes	No	
		Do you feel that your situation is hopeless?
		Do you think most people are better off than you are?
		Are you basically satisfied with your life?
		Are you in good spirits most of the time?
		Do you feel happy most of the time?
		Do you think it is wonderful to be alive?
		Do you feel full of energy?

Physician Signature:

Outlook Support Revised 9/07 BH, Reviewed 01/2008 BH, Revised 12/2008 BH, reviewed 12/2009 BH