

Medicare Advantage 360 Comprehensive Assessment Form



Member first name		Date of birth / /
Member last name		Date of service / /
Member ID	Primary care provider National Provider Identifier	
Rendering provider		
Member's PCP		

Location

- Residence
- PCP office
- Facility
- Telehealth (audiovisual only)

Source

- Patient
- Other (name and relationship)

Reason for Exam

- 360 Annual Wellness Exam
- Other

Sex at birth

- Male
- Female
- Transgender

History of present illness

Active diagnosis

- See attached medical record, signed with credentials, and dated

Past medical history

Resolved diagnosis

- See attached medical record, signed with credentials, and dated

Surgical history

- Reviewed and no surgeries
- Prior organ transplant; specify site or organ

- See attached medical record, signed with credentials, and dated

Family History

- Reviewed and no relevant history
- Unknown history

Primary language spoken

- See attached medical record, signed with credentials, and dated

	Father	Mother	Children	Siblings
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High lipids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medications

- No current medications
- Medications reconciled
- See attached medical record, signed with credentials, and dated

List all medications, including OTCs, with dosage and frequency; not required if list of medications is attached.

Reporting CPT® Category II codes (Both codes must be used):

- 1159F Medication list documented in medical record
- 1160F Review of all medications by prescriber documented in medical record

Allergies

- No known drug allergies
- Allergies reviewed
- See attached medical record, signed with credentials, and dated

Habits**Tobacco use**

- Yes No

Interested in quitting tobacco?

- Yes No

Alcohol use

- Yes, drinks per day _____
- No

Interested in quitting alcohol?

- Yes No

Opioid evaluation

Has your patient required or used more than a 15-day supply of narcotic medication over the last 12 months for a nonterminal diagnosis?

- Yes No

If Yes, are there alternative options besides opioids for the patient's pain?

- Yes No

Social history**Marital status**

- Single
- Married
- Domestic partner
- Divorced
- Widowed

Lives

- Alone
- Spouse
- Institutional
- Family
- Other _____

High risk for sexually acquired diseases, including HIV

- Yes
- No

Illicit drug use

- Yes
- No

Hearing

- Normal
- Impaired/hearing aid

Activities of daily living and independent activities of daily living assessed

- Patient is independent Patient needs assistance

Needs assistance with

- | | |
|--|---|
| <input type="checkbox"/> Transferring | <input type="checkbox"/> Taking medications |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Driving/using transportation |
| <input type="checkbox"/> Mobility/walking | <input type="checkbox"/> Preparing meals |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Housework |
| <input type="checkbox"/> Laundry | <input type="checkbox"/> Shopping for groceries |
| <input type="checkbox"/> Toileting | <input type="checkbox"/> Using the telephone |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Home repair |
| <input type="checkbox"/> Handling finances | |

Reporting CPT II code: 1170F Functional status assessed

Cognitive observation by provider

- Normal
- Impaired

Advanced care planning and reporting CPT II codes

- Advance directive
- Medical power of attorney
- Living will
- ACP documented 1157F
- ACP discussion documented 1158F
- ACP discussion and plan documented 1123F

Fall risk screening (Fall risk: four or more reported)

- Unable to perform exam because of _____
 - Diagnoses (three or more existing)
 - Prior history of falls within three months
 - Incontinence/nocturia
 - Visual impairment
 - Impaired functional mobility
 - Environmental hazard
 - Polypharmacy
 - Pain affecting level of function
 - Cognitive impairment
- Total number of boxes marked _____
- Fall risk prevention discussed

Depression screening (18 years old and older)

- Screening not performed because the patient is unable to communicate or answer.

PHQ-2

a. Little interest or pleasure in doing things

- 0 Not at all
- 1 Several days
- 2 More than half the days
- 3 Nearly every day

b. Feeling down, depressed or hopeless

- 0 Not at all
- 1 Several days
- 2 More than half the days
- 3 Nearly every day

If the PHQ-2 equals 3 or greater, complete PHQ-9 document and attach results to the 360 form.

- PHQ-9 form/standard screening tool/clinical interview

Preventive screenings

Colorectal cancer screening

(All patients ages 45 to 75)

One of the following for compliance:

- Colonoscopy (every 10 years) Date _____
- FIT DNA (Cologuard) (every three years) Date _____
- Flexible sigmoidoscopy (every five years) Date _____
- CT colonography (every five years) Date _____
- FOBT (every year) Date _____
- Total colectomy Date _____
- Colostomy Date _____
- Colon cancer Date _____

Breast cancer screening

(Female ages 50 to 74 every 27 months)

One of the following for compliance:

- Mammogram Date _____
- Bilateral mastectomy
- Two unilateral mastectomies

Osteoporosis screening

(Female, 65+, every 24 months)

- DEXA Date _____

Name of osteoporosis medication and date prescribed:

Bladder control screening

During the last three months, has patient leaked urine (even a small amount)? Yes No

If yes, how much of a problem was it? (5 is severe)

- 1 2 3 4 5

Discussed urinary incontinence, including bladder training exercises, medication and surgery. Yes No

Pain screening

Assess the overall pain presence in the patient's day-to-day life. (No pain = 0; has pain = 1-10)

- 0 1 2 3 4 5
- 6 7 8 9 10

If pain, please add diagnosis and treatment plan in the Assessment and Plan section.

Reporting CPT II codes

- 0521F Plan of care to document pain is documented
- 1125F Pain severity quantified, pain present
- 1126F Pain severity quantified, no pain present

Physical activity screening

Climb several flights of stairs?

- Yes, limited a lot
- Yes, limited a little
- No, not limited at all

Perform moderate activity like moving a table or vacuuming?

- Yes, limited a lot
- Yes, limited a little
- No, not limited at all

Exercise regularly or take part in physical activity?

- Yes
- No

Advised to start or continue exercise, including stairs, increased walking, etc.?

- Yes
- No

Immunizations

Immunization education Yes No

- First COVID dose Date _____
- Second COVID dose Date _____
- Booster COVID dose Date _____
- Manufacturer _____

Influenza vaccine

Since July 1 of prior year (encourage recall from patient):

- Yes No Date _____

Pneumococcal vaccine

Recommended at least one year apart (ages 65+)

- PCV13 Date _____
- PPSV23 Date _____

Diabetes mellitus annual screening and labs

HbA1C (83036, 83037) Date _____ Result _____

Reporting CPT II codes: 3044F < 7.0%, 3051F ≥7.0% and <8.0%, 3052F ≥ 8.0% and ≤9.0%, 3046F >9.0%

EGFR (80047-80048, 80050, 80053, 80069, 82565) Date _____ Result _____

and urine albumin (82043) Date _____ Result _____

Urine creatinine (82560) Date _____ Result _____ or urine albumin creatinine ratio (UACR) Date _____ Result _____

Date of last retinal or dilated eye exam by an eye care professional _____

Reporting CPT II Codes: 2023F, 2025F or 2033F for negative retinopathy; 2022F, 2024F or 2026F for positive/unknownRetinopathy results Positive Negative Bilateral absence of eyes Bilateral eye enucleation**Foot exam**

Complete for diabetic patients and patients with neuropathic complaints

Patient reports

- Burning, tingling, numbness in feet
- Previous foot ulcer
- Pain or cramping in calf area during exercise
- None of these

Inspection

- Infection
- Calluses or corns

Nail disorders

- Ulceration
- Skin breaks
- Foot deformity
- None of these

Pulses**Left**

- Normal
- Abnormal

Right

- Normal
- Abnormal

Neuropathy**Left**

- Absent
- Present

Right

- Absent
- Present

Complications due to diabetes (Check all that apply)

- Peripheral vascular disease
- Peripheral neuropathy
- Ulcer
- Gangrene
- Amputation: date, side and level _____
- None of these

Patients diagnosed with chronic obstructive pulmonary disease

GOLD stage _____

Maintenance Rx prescribed Yes NoRescue Rx prescribed Yes No

Self-management plan for exacerbation

Antibiotics Yes NoSteroids Yes No**Patients diagnosed with chronic heart failure**Prescribed Yes NoACE or ARB Yes NoBeta blocker Yes NoNeprilysin inhibitor Yes NoAldosterone receptor antagonists Yes No**Left ventricular ejection fraction**

Result and date _____

New York Heart Association Class 1 2 3 4**Coronary artery disease**

If statin prescribed, what intensity?

 Mild Moderate-high

Review of systems

	Negative	Positive or findings		Negative	Positive or findings
General	<input type="checkbox"/>		Neurological	<input type="checkbox"/>	
Head, eyes, ears, nose and throat	<input type="checkbox"/>		Skin	<input type="checkbox"/>	
Cardiac	<input type="checkbox"/>		Psychiatric	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>		Endocrine	<input type="checkbox"/>	
Gastronintestinal	<input type="checkbox"/>		Hematological	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>		Genitourinary	<input type="checkbox"/>	

Vitals

Height in inches	Weight in pounds	BMI	Temperature (F°)	Blood pressure	Heart rate	Respiratory rate

Complete vitals unless audiovisual telehealth visit; then collect patient reported BP with digital device.

Physical exam

	Normal	Abnormal or findings
General	<input type="checkbox"/>	
HEENT	<input type="checkbox"/>	
Neck	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	
Breast	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	
Extremities	<input type="checkbox"/>	
GU	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	
Psychiatric	<input type="checkbox"/>	
Lymphatic	<input type="checkbox"/>	

Reporting CPT II codes

BMI: 3008F

Blood pressure:

- 3074F SBP < 130 mmHg
- 3075F SBP 130-139 mmHg
- 3077F SBP ≥ 140 mmHg
- 3078F DBP < 80 mmHg
- 3079F DBP 80-89 mmHg
- 3080F DBP ≥ 90 mmHg

HMR reviewed and updated on today's visit? Yes No

Today's Assessment and Plan, signed with credentials, and dated attached?

Yes No

If no HMR or Assessment and Plan attached, please complete the Assessment and Plan or the following Appendix: Current Conditions.

Diagnoses descriptions

(No ICD-10 codes only)

Treatment plan

Medications, follow-up plan, diet, lab order, referral, etc. (Please describe)

Coordination of care

None See attached medical record, signed with credentials, and dated
 (List any providers or specialists involved in the patient's care and any supplier of equipment.)

Behavioral health referral

Yes No

Case management referral

Yes No

Social needs screening

Housing stability

What is the patient's living situation today?

- Patient has a steady place to live
- Patient has a place to live today, but is worried about losing it in the future
- Patient does not have a steady place to live (temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

Does the patient have problems with any of the following?

Choose all that apply.

- Pests such as bugs, ants or mice
- Mold
- Lead paint or pipes
- Lack of heat
- Oven or stove not working
- Smoke detectors missing or not working
- Water leaks
- None of the above

Access to transportation

In the past 12 months, has lack of reliable transportation kept the patient from medical appointments, meetings or work, or from getting things needed for daily living?

- Yes
- No

Food security

Within the past 12 months, did the patient worry that food would run out before they got money to buy more.

- Often true
- Sometimes true
- Never true

Within the past 12 months, the food the patient bought just didn't last and they didn't have money to get more.

- Often true
- Sometimes true
- Never true

Check any that apply

- Care coordination
 - Social concerns
 - Patient education
 - Other (specify) _____
- If yes, please specify

Rendering name		Rendering signature	
Rendering NPI	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA	Date	/ /
Supervising physician name (if applicable)		Supervising physician signature (if applicable)	
<input type="checkbox"/> MD <input type="checkbox"/> DO		Date / /	

Appendix: Current conditions

This appendix is **optional** for the 360 Comprehensive Assessment. It may be helpful to follow during our members' visits.

Cardiovascular

<input type="checkbox"/> Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Myocardial infarction <input type="checkbox"/> Ischemic <input type="checkbox"/> Non-ischemic Date _____	<input type="checkbox"/>				
<input type="checkbox"/> Angina pectoris	<input type="checkbox"/>				
<input type="checkbox"/> CAD <input type="checkbox"/> CAD with angina pectoris Vessel(s) <input type="checkbox"/> native <input type="checkbox"/> graft	<input type="checkbox"/>				
<input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Presence of internal cardiac defibrillator Type (specify) _____	<input type="checkbox"/>				
<input type="checkbox"/> CHF <input type="checkbox"/> Left heart failure <input type="checkbox"/> Right heart failure <input type="checkbox"/> Diastolic <input type="checkbox"/> Systolic <input type="checkbox"/> Systolic and diastolic	<input type="checkbox"/>				
<input type="checkbox"/> Biventricular heart failure	<input type="checkbox"/>				
<input type="checkbox"/> Pulmonary hypertension <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	<input type="checkbox"/>				
<input type="checkbox"/> Valvular disease	<input type="checkbox"/>				
<input type="checkbox"/> Hyperlipidemia <input type="checkbox"/> Mixed <input type="checkbox"/> Familial <input type="checkbox"/> Statin prescribed <input type="checkbox"/> Statin intolerant	<input type="checkbox"/>				
<input type="checkbox"/> Carotid artery stenosis <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/>				
<input type="checkbox"/> Atrial fibrillation <input type="checkbox"/> Paroxysmal <input type="checkbox"/> Persistent <input type="checkbox"/> Long-standing persistent <input type="checkbox"/> Permanent (chronic)	<input type="checkbox"/>				
<input type="checkbox"/> Sick Sinus Syndrome <input type="checkbox"/> With pacemaker <input type="checkbox"/> Without pacemaker	<input type="checkbox"/>				
<input type="checkbox"/> Tachycardia Type (specify) _____	<input type="checkbox"/>				
<input type="checkbox"/> Essential hypertension <input type="checkbox"/> Resistant hypertension	<input type="checkbox"/>				
<input type="checkbox"/> HTN heart disease <i>with</i> CHF (add specific CHF above)	<input type="checkbox"/>				
<input type="checkbox"/> HTN heart disease <i>without</i> CHF	<input type="checkbox"/>				
<input type="checkbox"/> Hypertensive chronic kidney disease (add specific stage of CKD to renal section)	<input type="checkbox"/>				
<input type="checkbox"/> Hypertensive heart and CKD (add specific stage of CKD to renal section) <input type="checkbox"/> With CHF (add specific CHF above) <input type="checkbox"/> Without CHF	<input type="checkbox"/>				
<input type="checkbox"/> Chronic deep vein thrombosis	<input type="checkbox"/>				
<input type="checkbox"/> Atherosclerosis of the extremities <input type="checkbox"/> Claudication <input type="checkbox"/> Rest pain ulceration <input type="checkbox"/> Rest pain	<input type="checkbox"/>				
<input type="checkbox"/> Other peripheral vascular disease	<input type="checkbox"/>				
<input type="checkbox"/> Atherosclerosis of aorta <input type="checkbox"/> Abdominal aortic aneurysm <input type="checkbox"/> Thoracic aortic aneurysm	<input type="checkbox"/>				
<input type="checkbox"/> Other diagnosis (specify) _____	<input type="checkbox"/>				

Nutritional/metabolic/endocrine

<input type="checkbox"/> Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Protein calorie malnutrition <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Cachexia	<input type="checkbox"/>				
<input type="checkbox"/> Overweight (BMI 25.0 - 29.9)	<input type="checkbox"/>				
<input type="checkbox"/> Obesity (BMI 30 - 39.9)	<input type="checkbox"/>				
<input type="checkbox"/> Morbid obesity (BMI > 40)	<input type="checkbox"/>				
<input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Acquired (post-surgical) <input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/>				
<input type="checkbox"/> Prediabetes	<input type="checkbox"/>				
<input type="checkbox"/> Vitamin D deficiency	<input type="checkbox"/>				
<input type="checkbox"/> Other diagnosis (specify) _____	<input type="checkbox"/>				

Diabetes mellitus

Document all comorbid manifestations.

<input type="checkbox"/> Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> DM <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Insulin <input type="checkbox"/> Oral medications	<input type="checkbox"/>				
<input type="checkbox"/> DM with kidney complications <input type="checkbox"/> CKD (include stage in renal section)	<input type="checkbox"/>				
<input type="checkbox"/> DM with neurological complications <input type="checkbox"/> Mononeuropathy <input type="checkbox"/> Polyneuropathy <input type="checkbox"/> Gastroparesis <input type="checkbox"/> Other _____	<input type="checkbox"/>				
<input type="checkbox"/> DM with ophthalmic complications <input type="checkbox"/> Retinopathy <input type="checkbox"/> Proliferative <input type="checkbox"/> Non-proliferative <input type="checkbox"/> With macular edema <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/>				
<input type="checkbox"/> DM with circulatory complications <input type="checkbox"/> Peripheral angiopathy / peripheral vascular disease <input type="checkbox"/> With gangrene <input type="checkbox"/> Without gangrene	<input type="checkbox"/>				
<input type="checkbox"/> DM with skin complications <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Non-pressure chronic ulcer <input type="checkbox"/> Location (specify) _____	<input type="checkbox"/>				
<input type="checkbox"/> DM with other complications <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Hyperglycemia	<input type="checkbox"/>				
<input type="checkbox"/> DM with oral complications <input type="checkbox"/> Periodontal <input type="checkbox"/> Other _____	<input type="checkbox"/>				
<input type="checkbox"/> DM with arthropathy <input type="checkbox"/> Neuropathic <input type="checkbox"/> Other _____	<input type="checkbox"/>				

Respiratory

<input type="checkbox"/> Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> COPD <input type="checkbox"/> With oxygen dependence <input type="checkbox"/> With exacerbation	<input type="checkbox"/>				
<input type="checkbox"/> Chronic bronchitis <input type="checkbox"/> With oxygen dependence <input type="checkbox"/> With exacerbation	<input type="checkbox"/>				
<input type="checkbox"/> Emphysema <input type="checkbox"/> With oxygen dependence <input type="checkbox"/> With exacerbation	<input type="checkbox"/>				
<input type="checkbox"/> Mesothelioma Location _____	<input type="checkbox"/>				
<input type="checkbox"/> Asthma <input type="checkbox"/> Intermittent <input type="checkbox"/> Persistent <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/>				
<input type="checkbox"/> Bronchiectasis <input type="checkbox"/> With Exacerbation <input type="checkbox"/> With acute lower respiratory infection	<input type="checkbox"/>				
<input type="checkbox"/> Obstructive sleep apnea	<input type="checkbox"/>				
<input type="checkbox"/> Chronic respiratory failure	<input type="checkbox"/>				
<input type="checkbox"/> Pulmonary fibrosis	<input type="checkbox"/>				
<input type="checkbox"/> Tracheostomy	<input type="checkbox"/>				
<input type="checkbox"/> Other diagnosis (specify) _____	<input type="checkbox"/>				

Musculoskeletal

<input type="checkbox"/> Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Rheumatoid arthritis (requiring disease modifying therapy) <input type="checkbox"/> Psoriatic arthritis	<input type="checkbox"/>				
<input type="checkbox"/> Systemic lupus erythematosus	<input type="checkbox"/>				
<input type="checkbox"/> Osteoarthritis Locations _____ <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/>				
<input type="checkbox"/> Osteopenia Location _____	<input type="checkbox"/>				
<input type="checkbox"/> Osteoporosis Type <input type="checkbox"/> Senile <input type="checkbox"/> Postmenopausal <input type="checkbox"/> Unspecified					
<input type="checkbox"/> Has the patient had a fracture in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If a fracture occurred, note specific bone location <input type="checkbox"/> Right <input type="checkbox"/> Left _____	<input type="checkbox"/>				
<input type="checkbox"/> S/P amputation <input type="checkbox"/> Presence of artificial limb Location _____ <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/>				
<input type="checkbox"/> Other diagnosis (specify) _____	<input type="checkbox"/>				

Skin/Subcutaneous

<input type="checkbox"/> Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Pressure ulcer <input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Stage 4 <input type="checkbox"/> Unstageable	<input type="checkbox"/>				
<input type="checkbox"/> Non-pressure ulcer Location (specify) _____ <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/>				
<input type="checkbox"/> Venous stasis ulcer Location (specify) _____ <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/>				
<input type="checkbox"/> Pemphigus	<input type="checkbox"/>				
<input type="checkbox"/> Pemphigoid	<input type="checkbox"/>				
<input type="checkbox"/> Other diagnosis (specify) _____	<input type="checkbox"/>				

Renal/Urinary

<input type="checkbox"/> Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Chronic kidney disease <input type="checkbox"/> Stage 1 (GFR>90) <input type="checkbox"/> Stage 2 (GFR 60-89) <input type="checkbox"/> Proteinuria (CKD 1 and 2 must have abnormal structural test, i.e. micro-albumin)	<input type="checkbox"/>				
<input type="checkbox"/> Stage 3A (GFR 45-59) <input type="checkbox"/> Stage 3B (GFR 30-44) <input type="checkbox"/> Stage 4 (GFR 15-29) <input type="checkbox"/> Stage 5 (GFR< 15)	<input type="checkbox"/>				
<input type="checkbox"/> End-stage renal disease Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>				
<input type="checkbox"/> Arteriovenous fistula <input type="checkbox"/> Graft <input type="checkbox"/> Catheter	<input type="checkbox"/>				
<input type="checkbox"/> Urinary incontinence (check one) <input type="checkbox"/> Unspecified <input type="checkbox"/> Stress <input type="checkbox"/> Urge	<input type="checkbox"/>				
<input type="checkbox"/> Benign prostatic hyperplasia <input type="checkbox"/> With lower urinary tract symptoms (specify) _____ <input type="checkbox"/> Without LUTS	<input type="checkbox"/>				
<input type="checkbox"/> Cystostomy	<input type="checkbox"/>				
<input type="checkbox"/> Secondary hyperparathyroidism of renal origin	<input type="checkbox"/>				
<input type="checkbox"/> Erectile dysfunction	<input type="checkbox"/>				
<input type="checkbox"/> Other diagnosis (specify) _____	<input type="checkbox"/>				

Gastrointestinal

<input type="checkbox"/> Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Gastroesophageal reflux disease	<input type="checkbox"/>				
<input type="checkbox"/> Barrett's esophagus	<input type="checkbox"/>				
<input type="checkbox"/> Chronic hepatitis (specify type) _____	<input type="checkbox"/>				
<input type="checkbox"/> Alcoholic hepatitis <input type="checkbox"/> Ascites	<input type="checkbox"/>				
<input type="checkbox"/> Toxic liver disease (specify type) _____ <input type="checkbox"/> With chronic persistent hepatitis <input type="checkbox"/> With chronic lobular hepatitis <input type="checkbox"/> With fibrosis and cirrhosis of liver <input type="checkbox"/> With chronic active hepatitis without ascites <input type="checkbox"/> With chronic active hepatitis with ascites	<input type="checkbox"/>				
<input type="checkbox"/> End stage liver disease	<input type="checkbox"/>				
<input type="checkbox"/> Primary sclerosing cholangitis <input type="checkbox"/> Other cholangitis (specify) _____	<input type="checkbox"/>				
<input type="checkbox"/> Obstruction of bile duct	<input type="checkbox"/>				
<input type="checkbox"/> Pancreatitis, chronic	<input type="checkbox"/>				
<input type="checkbox"/> Crohn's disease Locations _____	<input type="checkbox"/>				
<input type="checkbox"/> Cirrhosis liver <input type="checkbox"/> Alcoholic <input type="checkbox"/> Non-alcoholic	<input type="checkbox"/>				
<input type="checkbox"/> Ulcerative colitis, if complications exist, specify _____	<input type="checkbox"/>				
<input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> With diarrhea <input type="checkbox"/> Without diarrhea	<input type="checkbox"/>				
<input type="checkbox"/> J Tube <input type="checkbox"/> G Tube	<input type="checkbox"/>				

Gastrointestinal cont'd

	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Colostomy <input type="checkbox"/> Ileostomy	<input type="checkbox"/>				
<input type="checkbox"/> Other diagnosis (specify) _____	<input type="checkbox"/>				

Eye

<input type="checkbox"/> Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Cataract <input type="checkbox"/> Senile <input type="checkbox"/> Diabetic <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/>				
<input type="checkbox"/> Glaucoma <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/>				
<input type="checkbox"/> Macular degeneration <input type="checkbox"/> Exudative <input type="checkbox"/> Nonexudative <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/>				
<input type="checkbox"/> Legal blindness <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Other diagnosis (specify) _____	<input type="checkbox"/>				
<input type="checkbox"/> Retinopathy not due to diabetes; specify laterality, type, severity and macular edema status _____ (See above for diabetic retinopathy.)	<input type="checkbox"/>				
<input type="checkbox"/> Other diagnosis (specify) _____	<input type="checkbox"/>				

Active neoplasm and current treatment

<input type="checkbox"/> Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Colon cancer <input type="checkbox"/> Colectomy date _____ <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation	<input type="checkbox"/>				
<input type="checkbox"/> Metastatic (specify) _____	<input type="checkbox"/>				
<input type="checkbox"/> Breast cancer Neoplasm breast site <input type="checkbox"/> Right <input type="checkbox"/> Left Treatment <input type="checkbox"/> Mastectomy <input type="checkbox"/> Bilateral <input type="checkbox"/> Unilateral <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation <input type="checkbox"/> Hormonal therapy	<input type="checkbox"/>				
<input type="checkbox"/> If ductal carcinoma in situ <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/>				
<input type="checkbox"/> Metastatic (specify) _____	<input type="checkbox"/>				
<input type="checkbox"/> Prostate cancer <input type="checkbox"/> Prostatectomy Treatment _____	<input type="checkbox"/>				
<input type="checkbox"/> Metastatic (specify) _____	<input type="checkbox"/>				
<input type="checkbox"/> Lung cancer <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Upper lobe <input type="checkbox"/> Lower lobe <input type="checkbox"/> Other _____	<input type="checkbox"/>				
Treatment <input type="checkbox"/> Lobectomy <input type="checkbox"/> Pneumonectomy <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation	<input type="checkbox"/>				
<input type="checkbox"/> Metastatic (specify) _____	<input type="checkbox"/>				
<input type="checkbox"/> Skin cancer Specify type and site _____	<input type="checkbox"/>				
<input type="checkbox"/> Melanoma in situ (specify site) _____	<input type="checkbox"/>				
<input type="checkbox"/> Other malignancies, primary or secondary (specify) _____	<input type="checkbox"/>				

Blood disorders and current treatment

<input type="checkbox"/> Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Myelodysplastic disease	<input type="checkbox"/>				
<input type="checkbox"/> Malignant ascites	<input type="checkbox"/>				
<input type="checkbox"/> Malignant pleural effusion (specify primary site if known) _____	<input type="checkbox"/>				
<input type="checkbox"/> Benign carcinoid tumor (specify site) _____	<input type="checkbox"/>				
<input type="checkbox"/> Myelodysplastic disease	<input type="checkbox"/>				
<input type="checkbox"/> Multiple myeloma <input type="checkbox"/> Current <input type="checkbox"/> In remission <input type="checkbox"/> Relapse	<input type="checkbox"/>				
<input type="checkbox"/> Drug-induced neutropenia (specify drug) _____	<input type="checkbox"/>				

Blood disorders and current treatment *cont'd*

	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Due to CKD <input type="checkbox"/> Drug-induced (specify drug) _____	<input type="checkbox"/>				
<input type="checkbox"/> Anemia <input type="checkbox"/> Due to chemotherapy <input type="checkbox"/> B-12 <input type="checkbox"/> Iron <input type="checkbox"/> General	<input type="checkbox"/>				
<input type="checkbox"/> Sickle cell <input type="checkbox"/> Other diagnosis (specify) _____	<input type="checkbox"/>				

Infectious disease and current treatment

<input type="checkbox"/> Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Thrombocytopenia <input type="checkbox"/> Immune TCP <input type="checkbox"/> Congenital and hereditary TTP <input type="checkbox"/> Other primary _____ <input type="checkbox"/> Other unspecified _____	<input type="checkbox"/>				
<input type="checkbox"/> HIV+ <input type="checkbox"/> AIDS	<input type="checkbox"/>				
<input type="checkbox"/> Other diagnosis (specify) _____	<input type="checkbox"/>				

Neurological

<input type="checkbox"/> Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Cerebrovascular accident with sequelae (specify below)	<input type="checkbox"/>				
Specify late effect <input type="checkbox"/> Cognitive (specify) _____	<input type="checkbox"/>				
<input type="checkbox"/> Speech/language <input type="checkbox"/> Aphasia	<input type="checkbox"/>				
<input type="checkbox"/> Dysphagia <input type="checkbox"/> Other _____	<input type="checkbox"/>				
<input type="checkbox"/> Monoplegia <input type="checkbox"/> Dominant <input type="checkbox"/> Nondominant <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Upper <input type="checkbox"/> Lower	<input type="checkbox"/>				
<input type="checkbox"/> Hemiplegia/hemiparesis <input type="checkbox"/> Dominant <input type="checkbox"/> Nondominant <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Upper <input type="checkbox"/> Lower	<input type="checkbox"/>				
<input type="checkbox"/> Weakness <input type="checkbox"/> Dominant <input type="checkbox"/> Nondominant <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/>				
<input type="checkbox"/> History of trauma	<input type="checkbox"/>				
<input type="checkbox"/> Monoplegia <input type="checkbox"/> Dominant <input type="checkbox"/> Nondominant <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Upper <input type="checkbox"/> Lower	<input type="checkbox"/>				
<input type="checkbox"/> Hemiplegia/hemiparesis <input type="checkbox"/> Dominant <input type="checkbox"/> Nondominant <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/>				
<input type="checkbox"/> Quadriplegia	<input type="checkbox"/>				
<input type="checkbox"/> Migraine	<input type="checkbox"/>				
<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/>				
<input type="checkbox"/> Myasthenia gravis	<input type="checkbox"/>				
<input type="checkbox"/> Amyotrophic lateral sclerosis	<input type="checkbox"/>				
<input type="checkbox"/> Post-polio syndrome	<input type="checkbox"/>				
<input type="checkbox"/> Polyneuropathy other than due to diabetes (specify)	<input type="checkbox"/>				
<input type="checkbox"/> Parkinson's disease <input type="checkbox"/> With dementia <input type="checkbox"/> With behavioral disturbances	<input type="checkbox"/>				
<input type="checkbox"/> Seizures <input type="checkbox"/> Seizure disorder (epilepsy)	<input type="checkbox"/>				
<input type="checkbox"/> Other diagnosis (specify) _____	<input type="checkbox"/>				

Psychiatric

<input type="checkbox"/> Reviewed and no active disease	Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Dementia <input type="checkbox"/> Unspecified <input type="checkbox"/> Vascular (specify) _____	<input type="checkbox"/>				
<input type="checkbox"/> Senile <input type="checkbox"/> With delusions <input type="checkbox"/> With depression	<input type="checkbox"/>				

Psychiatric cont'd

		Meds	Monitor	Diet	Labs	Referral
<input type="checkbox"/> Alzheimer's disease	<input type="checkbox"/> Early onset <input type="checkbox"/> Late onset	<input type="checkbox"/>				
	<input type="checkbox"/> With dementia	<input type="checkbox"/>				
	<input type="checkbox"/> With dementia and behavioral disturbance	<input type="checkbox"/>				
<input type="checkbox"/> Depressive disorder	<input type="checkbox"/> Major depressive disorder <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/>				
	Occurrence <input type="checkbox"/> Single episode <input type="checkbox"/> Recurrent <input type="checkbox"/> Full remission <input type="checkbox"/> Partial remission	<input type="checkbox"/>				
	If severe <input type="checkbox"/> With psychotic symptoms (consider psych referral if symptoms are present, recurrent or suicidal)	<input type="checkbox"/>				
	<input type="checkbox"/> Without psychotic symptoms	<input type="checkbox"/>				
<input type="checkbox"/> Anxiety		<input type="checkbox"/>				
<input type="checkbox"/> Bipolar	<input type="checkbox"/> Current <input type="checkbox"/> In remission <input type="checkbox"/> Full <input type="checkbox"/> Partial	<input type="checkbox"/>				
	<input type="checkbox"/> With psychotic features <input type="checkbox"/> Without psychotic features	<input type="checkbox"/>				
	Current type <input type="checkbox"/> Depressed <input type="checkbox"/> Manic <input type="checkbox"/> Mixed	<input type="checkbox"/>				
	Current severity <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	<input type="checkbox"/>				
<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Paranoid <input type="checkbox"/> Simple <input type="checkbox"/> Undifferentiated	<input type="checkbox"/>				
	<input type="checkbox"/> Disorganized <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/>				
<input type="checkbox"/> Alcohol use	<input type="checkbox"/> Alcohol misuse <input type="checkbox"/> Alcohol dependence <input type="checkbox"/> In remission	<input type="checkbox"/>				
<input type="checkbox"/> Substance use	<input type="checkbox"/> Substance misuse <input type="checkbox"/> Dependence <input type="checkbox"/> In remission (specify) _____	<input type="checkbox"/>				
<input type="checkbox"/> Tobacco dependence		<input type="checkbox"/>				
<input type="checkbox"/> Anorexia nervosa		<input type="checkbox"/>				
<input type="checkbox"/> Bulimia nervosa		<input type="checkbox"/>				
<input type="checkbox"/> Other diagnosis (specify) _____		<input type="checkbox"/>				

Rendering name		Rendering signature	
Rendering NPI	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA	Date	/ /
Supervising physician name (if applicable)		Supervising physician signature (if applicable)	
<input type="checkbox"/> MD <input type="checkbox"/> DO		Date	/ /