North Olympic Healthcare NETWORK

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Thank you for participating in your **Medicare Annual Wellness Visit** with North Olympic Healthcare Network as recommended by your primary care provider.

Your provider understands that as we age our "preventive care" needs evolve and more attention needs to be given to our functional status and safety in addition to screening for certain diseases. Medicare recognizes this as well, and has developed a specific benefit called the **Annual Wellness Visit** that addresses these issues.

Your **Medicare Annual Wellness Visit** includes the following elements:

- Establish or update your medical and family history
- Review and list other doctors and suppliers involved in providing your care
- Review and update all of your medications and supplements including vitamins – how often and much of each is taken
- Record measurements of height, weight, body mass index, blood pressure and other routine measurements
- Screening for loss of sensory acuity
- Screening for any cognitive impairment
- Establish a screening schedule or checklist for the next 5 to 10 years
- Provide personalized risk assessment, health advice, and appropriate referrals to health education or preventive services, i.e. smoking cessation, diet, etc.
- Discussion about Advanced Directives

The Medicare Annual Wellness Visit does not have a co-pay requirement and does not include, or pay for, a physical exam and some lab work/blood draws. Specific health concerns are best addressed at another visit with your provider focused on those concerns. Your wellness visit is performed by a nurse specialist with collaboration and oversight by your primary care provider.

Because of these specific Medicare requirements for this examination, we have enclosed a questionnaire for you to **complete before the visit** to assist us in your assessment. **Please answer each question completely and return to NOHN as soon as possible**. Once we have received your completed questionnaire, **we will contact you about scheduling a special time for your Annual Wellness Visit with our nurse specialist:**

Pre-Visit Checklist

- ☐ Fill out questions in the enclosed packet
- ☐ Complete any ordered lab work as soon as possible

Medicare **Annual Wellness Visit**

Health Risk Assessment

Name _____

Date of birth _____

Circle your responses. Your answers will be kept confidential.

General health

How would you rate your health compared to others your age?	**Worse**	**Same**	**Better**

Hearing and vision

1. Do you feel that a hearing difficulty limits your life?	**Yes**	**No**
2. Do you feel that a vision difficulty limits your life?	**Yes**	**No**

Activities of daily living

1. Do you need help with dressing, eating, bathing, going to the bathroom, walking, or getting in or out of bed?		**Yes**	**No**	
2. Do you need help with preparing meals, transportation, shopping, managing your finances, keeping house, making calls, or taking your medicine?		**Yes**	**No**	
3. If you drive, have you had a car accident in the last year, or have you been asked to stop driving?		**Yes**	**No**	**I do not drive**
4. Who do you live with?	**Alone**	**Partner /spouse**	**Child**	**Parent**
	Other:			
5. Are you working or volunteering?		**Yes**	**No**	
If you do, what do you do, and for how many hours a week?		**< 10**	**11-20**	**21+**

Home safety

Does your home have throw rugs, poor lighting, a slippery bathtub or shower or other hazards?	**Yes**	**No**

Fall risk (STEADI questions — Stopping Elderly Accidents, Deaths and Injuries)

1. Have you fallen in the past year?	**Yes**	**No**
a. *If you have fallen*, how many times?		
b. *If you have fallen*, were you injured?	**Yes**	**No**
2. Do you feel unsteady when standing or walking?	**Yes**	**No**
3. Do you worry about falling?	**Yes**	**No**

▶ **If you answered yes to *any* of the above 3 questions**, please also answer the following:

4. Do you use (or were you told to use) a cane or walker to get around safely?	**Yes**	**No**
5. Do you have to steady yourself by holding onto furniture when moving about your home?	**Yes**	**No**
6. Do you need to push with your hands to stand up from a chair?	**Yes**	**No**
7. Do you have trouble stepping up onto a curb?	**Yes**	**No**
8. Do you often have to rush to the toilet?	**Yes**	**No**
9. Have you lost some of the feeling in your feet?	**Yes**	**No**
10. Do you take any medicine that makes you feel light-headed or tired?	**Yes**	**No**
11. Do you take medicine to help you sleep or improve your mood?	**Yes**	**No**
12. Do you feel sad or depressed?	**Yes**	**No**

Continue here.

Incontinence screening

Do you have trouble holding your bowels or bladder?	**Yes**	**No**

Advance care planning

Do you have an Advance Directive with designation of a Health Care Representative/Power of Attorney?	**No**	**Yes**	**Not sure**

Nutrition

1. How is your appetite?	**Poor**	**Fair**	**Good**
2. Have you lost weight without meaning to in the last year?	**Yes**	**No**	
3. Do you eat two or more servings of fruits and vegetables every day?	**No**	**Yes**	

Exercise

How many days a week do you exercise?	
If you exercise: What do you do? For about how many minutes each time?	

Substances

1. Do you smoke or chew tobacco? *If you do*, how much and how often?	**Yes**	**Not currently**	**Never**
2. Do you drink alcohol?	**Yes**	**Not currently**	**Never**
If you drink alcohol, how often and how much?	*I drink…* **Monthly or less** **2-4 times a month** **2-3 times a week** **4 or more times a week**		
Standard drinks are 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of liquor each	*I drink…* **1–2 2–4 5–6 7–9 10+** *…drinks in a typical day when I'm drinking.*		
3. Do you use any recreational drugs? *If you've used anything in the last year, please list.*	**Yes**	**Not currently**	**Never**
	Marijuana **Others: _____**		

Depression screening (PHQ-2/9)

Over the last 2 weeks, how often have you been bothered by any of the following? *Please circle one response for each question.*	Not at all	Several days	More than half the days	Nearly every day
1. Do you have little interest or pleasure in doing things?	**0**	**1**	**2**	**3**
2. Do you feel down, depressed or hopeless?	**0**	**1**	**2**	**3**

▶ **If the total score from the above questions is 3 or more**, please also answer the following:

	Not at all	Several days	More than half the days	Nearly every day
3. Do you have trouble falling asleep, staying asleep or are you sleeping too much?	**0**	**1**	**2**	**3**
4. Do you feel tired or have little energy?	**0**	**1**	**2**	**3**
5. Do you have poor appetite or overeating?	**0**	**1**	**2**	**3**
6. Do you feel bad about yourself, or feel that you're a failure or have let yourself or your family down?	**0**	**1**	**2**	**3**
7. Do you have trouble concentrating on things, such as reading or watching television?	**0**	**1**	**2**	**3**
8. Do you move or speak so slowly that other people have noticed? Or, the opposite — have you been so fidgety or restless that you have been moving around a lot more than usual?	**0**	**1**	**2**	**3**
9. Have you had thoughts that you would be better off dead, or of hurting yourself?	**0**	**1**	**2**	**3**
10. How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	**Not difficult at all**		**Very difficult**	
	Somewhat difficult		**Extremely difficult**	