Health Partners Plans

Return to: Health Partners Plans Medicare
Fax: (267) 515-6654
Please retain a copy and place in the member's medical chart.

Comprehensive Patient Assessment Form

Member ID: _____ Rendering Provider (NPI): _____

First Name: _____ Rendering Provider Name: _____

Last Name: _____

Date of Birth: _____ **Date of Service:** _____

Vitals/Systems:

Height: _____ BMI Value: _____

Note: BMI value must be calculated

Weight: _____

Medication Review:

There are no medications present for the Member: ☐ *(check if true)*

Medication Name(s)

1.)	10.)
2.)	11.)
3.)	12.)
4.)	13.)
5.)	14.)
6.)	15.)
7.)	16.)
8.)	17.)
9.)	18.)

*Medication Review must be conducted by a prescribing practitioner or clinical pharmacist
**Medication Review List can also be attached and returned with this form in substitute of the above section

Check Box if Present

If the member is taking a maintenance drug, are there adherence issues? ☐

Member Activities

Physical Activity:

	Results
In the past 7 days, how many days did the member exercise?	
On days when the member exercised, for how long did they exercise (in minutes)?	

Member does not exercise ☐ *(check if true)*

Nutrition Review:

In the past 7 days:

	Servings per day
How many servings of fruit and vegetables did the member eat each day?	
How many servings of high fiber or whole grain foods did the member eat each day?	
How many servings of fried or high-fat foods did the member eat each day?	
How many sugar-sweetened (not diet) beverages did the member consume each day?	

Sleep Activity:

	Results
Each night, how many hours of sleep does the member usually get?	
Do you snore or has anyone told you that you snore?	Yes ☐ No ☐

Care for Older Adults ***(Ages 65 or older) :***

I.) Advanced Care Planning

	Yes	*No*	*Date:*
Member already has Advanced Care Planning (in prior year):	☐	☐	_____
Discussed Advanced Directives with Member during current visit:	☐	☐	_____

II.) Functional Status Assessment

a.) Member Ambulatory Status: (check all that apply)

☐ Independent ☐ Wheelchair ☐ Bedbound ☐ Walker ☐ Cane

b.) Amputations and/or Prostheses

Has the member had a prior amputation and/or use a prosthetic device? *Yes* ☐ *No* ☐

c.) Cognitive Status: (check one)

☐ Normal ☐ Abnormal Comments: _____

d.) Activities of Daily Living:

In the past 7 days, did the member need help from others to perform everyday activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet? *Yes* ☐ *No* ☐

e.) Instrumental Activities of Daily Living:

In the past 7 days, did the member need help from others to perform everyday activities such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking medications? *Yes* ☐ *No* ☐

III.) Pain Assessment

	Yes	*No*	*Date:*
Performed Pain Assessment:	☐	☐	_____

Overall Presence of Pain in the Patient's day to day life:

Method: Numeric Pain Intensity Scale (0/10): _____

Diagnosis Condition Verification:

There is no diagnosis condition present for the Member: ☐ *(check if true)*

Note:

Please remember to include all applicable diagnosis coding on the corresponding claim and document codes below (if known while filling out the form)

Condition:	***Present:***	***Diag Code***	***Condition:***	***Present:***	***Diag Code***
Diabetes	☐	_____	Rheumatoid Arthritis	☐	_____
CHF	☐	_____	Morbid Obesity	☐	_____
COPD	☐	_____	Cancer	☐	_____
Acute Renal Failure	☐	_____	Asthma	☐	_____
Depression, Bipolar, and Paranoid Disorders	☐	_____	Other Condition(s)	☐	
Hep C	☐	_____	Name1: _____		_____
Hypertension	☐	_____	Name2: _____		_____

Cardiovascular Conditions *(if applicable)* ***:***

Services:	***Service Date:***	***Results***	
1.) Blood Pressure Test:	_____		*Note: Controlled if < 140/90 mm Hg (or < 150/90 mm Hg for non-diabetic 60-85 members)*
2.) LDL Test:	_____		*Note: Controlled <100*

Is Member on Statin Therapy: Yes ☐ No ☐

Diabetic Services *(if applicable)* **:**

Diabetic Services:	***Service Date:***	***Results***	
1.) Diabetes HbA1c Test:			*Note: Controlled if < 9*
2.) Microalbuminuria Test:			
3.) Blood Pressure Test:			*Note: Controlled if < 140/90 mm Hg (or < 150/90 mm Hg for non-diabetic 60-85 members)*
4.) LDL Test:			*Note: Controlled <100*
5.) Retinal Eye Exam:			*Note: Must be completed by an eye care provider*

Member is free of Diabetes, or does the member have Gestational Diabetes? ☐ *(check if true)*

Preventive Services and Education *(complete if applicable)* **:**

I.) Preventive Services

Breast Cancer Screening *(in last 2 years)* **:**

Mammography: ☐ Date: _____
Results: _____

Exclusion:
Bilateral Mastectomy ☐ Date: _____

* Test Results must be included to meet the measure specification

Colorectal Cancer Screening:

FOBT (Every Year): ☐ Date: _____
Results: _____

Flexible Sigmoidoscopy (Every 5 years): ☐ Date: _____
Results: _____

Colonoscopy (Every 10 years): ☐ Date: _____
Results: _____

Exclusion : Colectomy ☐ Date: _____

* Test Results must be included to meet the measure specification

Osteoporosis Screening:

Bone Density Test: ☐ Date: _____
Results: _____

* Test Results must be included to meet the measure specification

II.) Discuss the following with the Member

	Discussion :	***At Risk :***
Prior Medical and Family History	☐	☐
Fall Risk Screening	☐	☐
Depression Screening	☐	☐
Annual Influenza Vaccine	☐	☐
Urinary Incontinence Screening	☐	☐
Stress/Anxiety Screening	☐	☐

III.) Member Referrals ***Recommendations:***

Case Management Referral ☐ For: _____
_____

Behavioral Health Referral ☐ For: _____
_____

Medication Therapy Mgmt. Referral ☐ For: _____
_____

IV.) Member Behavior ***Present:***

Tobacco Use ☐
Alcohol Abuse ☐

☐ By checking this box, you acknowledge that you have discussed all member problems, evaluated preexisting conditions, and discussed treatments. Evidence of these discussions has been documented in the member's medical chart.

(if applicable)
Preparer / Nurse Practitioner Name: _____
*HPP Credentialed

(if applicable)
Preparer / Nurse Practitioner Signature: _____
*HPP Credentialed

Physician Name: _____

Physician Signature: _____

Date: _____

This form must include a physician signature and date. Please retain a copy and place in the member's medical chart.