JAMISON
FAMILY MEDICINE
COMPLETE HEALTH & WELLNESS

9631 N Nevada St. Suite 210

Spokane, WA 99218

Phone (509)319-2430 * Fax (877)568-2402

Dear _____,

We have scheduled an Annual Wellness visit with _____ on _____. We wanted to advise you that Medicare has set very specific guidelines for this visit that may be different from physicals or wellness visits you have had in the past.

Your Annual Wellness visit will be a health review and will concentrate on preventative medicine. Please schedule a separate appointment for specific conditions or illness concerns you may have.

Please fill out the entire Health Risk Assessment form at your convenience and please BRING TO YOUR APPOINTMENT. Your healthcare provider will be reviewing this form with you at your visit.

Please note the preparations prior to having your wellness labs drawn: **No alcohol** for 72 hours before, do not have anything by mouth after 7pm the night before your bloodwork (this includes mints and gum, **you can drink water)** If you are on medications, please take them as prescribed. If food is required, eat a small amount. This again, is for lab work purposes.

PLEASE BRING IN A LIST OF YOUR MEDICATION AND A LIST OF ANY SURGERIES YOU HAVE HAD.

Thank you for your time and choosing Jamison Family Medicine has your health care team.

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Are you here for an Annual Wellness Exam?

What to Expect:

- **Cognitive assessment is performed to look for signs of Alzheimer's disease or dementia.**
- **A review of your medical and family history**
- **Developing or updating a list of current providers and prescriptions.**
- **A list of risk factors and treatment options for you**
- **Height, weight, blood pressure, and other routine measurements**
- **Personalized prevention plan to help prevent disease and disability based on your current health and risk factors.**
- **A screening schedule (like a checklist) for appropriate preventive services as Medicare allows**

If you are seen for a new issue at the same time as your Annual Wellness exam, you will be asked to pay your copay (if applicable) and your insurance will be billed for a regular office visit, and we will need to get your wellness visit rescheduled.

Thank you.

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Dear Patient,

We want you to receive wellness care, health care that may lower your risk of illness or injury. Medicare pays for some wellness care, but it does not pay for all the wellness care you might need. We want you to know about your Medicare benefits and how we can help you get the most from them.

The term "physical" is often used to describe wellness care. But Medicare does not pay for a traditional, head-to-toe physical. Medicare does pay for a wellness visit once a year to identify health risks and help you to reduce them. At your wellness visit, our health care team will take a complete health history and provide several other services:

- Screenings to detect cognitive impairment, depression, risk for falling and functional assessment.
- A limited physical exam to check your blood pressure, weight, vision, and other things depending on your age, gender, and level of activity.
- Recommendations for other wellness services and healthy lifestyle changes

Before your appointment, our staff will ask you some questions about your health and ask you complete the attached "Health Risk Assessment" form.

A Wellness visit does not deal with New or Existing health problems. Please let our scheduling staff know if you need the providers help with a health problem, a medication refill or something else. If your provider chooses to exam a separately identifiable problem, you will be required to pay your copay (if applicable) and it will be billed to your insurance as a regular office visit, we will need to reschedule your wellness. You may also opt to schedule a separate service for another day to discuss these concerns and complete your wellness as scheduled.

We hope to help you get the most from your Medicare wellness benefits. Please contact Medicare with questions regarding benefits. Thank you!

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Name:_____

DOB: _____ Visit Date: _____

Provider Initials: _____

MEDICARE WELLNESS Visit Health Risk Assessment

Please complete this checklist before seeing your doctor or provider. Your response will help you receive the best health care possible.

1. Is this your first Wellness visit?
   Yes _____ No _____

2. Are you a female or a male?
   Male ____ Female _____

3. During the **past four weeks**, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad, or downhearted and blue?
   ___ Not at all
   ___ Slightly
   ___ Moderately
   ___ Quite a bit
   ___ Extremely

4. During the **past four weeks**, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?
   ___ Not at all
   ___ Slightly
   ___ Moderately
   ___ Quite a bit
   ___ Extremely

5. During the **past four weeks**, how much bodily pain have you generally had?
   ___ No pain
   ___ Very mild pain
   ___ Mild Pain
   ___ Moderate Pain
   ___ Severe pain

6. During the **past four weeks**, was someone available to help you if you needed and wanted help? (For example, if you felt very nervous, lonely or blue; got sick and had to stay in bed; needed someone to talk to; needed help with daily chores; or needed help just taking care of yourself.)
   ___ Yes, as much as I wanted
   ___ Yes, quite a bit
   ___ Yes, a little
   ___ No, not at all

7. During the **past four weeks**, what was the hardest physical activity you could do for at least 2 minutes?
   ___Very heavy
   ___ Heavy
   ___ Moderate
   ___ Light
   ___ Very light

8. Can you get to places out of walking distance without help? (For example, can you travel alone on buses, taxis, or drive your own car?)
   _____ Yes _____ No

9. Can you go shopping for groceries or clothes without someone's help?
   _____ Yes _____ No

10. Can you prepare your own meals?
    _____ Yes _____ No

11. Can you do your housework without help?
    _____ Yes _____ No

12. Because of any health problems, do you need the help of another person with your personal care needs such as eating, bathing, dressing, or getting around the house?
    _____ Yes _____ No

13. Can you handle your own money without help?
    _____ Yes _____ No

14. During the **past four weeks**, how would you rate your health in general?
    ___ Excellent
    ___ Very good
    ___ Good
    ___ Fair
    ___ Poor

15. Do you have trouble hearing the television or radio when others do not?
    _____ Yes _____ No

16. Do you have to strain or struggle to hear/understand conversations?
    _____ Yes _____ No

17. How have things been going for you during the past four weeks?
    ___ Very well; could hardly be better
    ___ Pretty well
    ___ Good and bad parts about equal
    ___ Pretty bad
    ___ Very bad; could hardly be worse

18. Are you having difficulties driving your car?
    ____ Yes, often
    ____ Sometimes
    ____ No
    ____ N/A I do not use a car

Name:_____

DOB:_____

19. Do you use your seatbelt 100 % of the time?
    _____ Yes _____ No

20. How often in the **past four weeks** have you been bothered by any of the following problems?
    Circle Answer

    Falling or dizzy when standing up.
    Never/Seldom/Sometimes/Often/ Always
    Sexual problems
    Never/Seldom/Sometimes/Often/ Always
    Trouble eating well.
    Never/Seldom/Sometimes/Often/ Always
    Teeth or denture problems.
    Never/Seldom/Sometimes/Often/ Always
    Problems using telephone.
    Never/Seldom/Sometimes/Often/ Always
    Tiredness or fatigue.
    Never/Seldom/Sometimes/Often/ Always

21. Have you fallen two or more times in the **past year**?
    _____ Yes _____ No

22. Are you afraid of falling?
    _____ Yes _____ No

23. Are you a smoker?
    ___Yes, and I might quit
    ___ Yes, but I'm not ready to quit
    ___ No

24. During the **past four weeks**, how many drinks of wine, beer or other alcoholic beverages did you have?
    ___ 10 or more drinks per week
    ___ 6-9 drinks per week
    ___ 2-5 drinks per week
    ___ One drink or less per week
    ___ No alcohol at all

25. Do you exercise for about 20 minutes three or more days a week?
    ___ Yes, most of the time
    ___ Yes, some of the time
    ___ No, I usually do not exercise this much

26. Have you been given any information to help you with the following:
    a. Hazards in your house that might hurt you?
       _____ Yes _____ No
    b. Keeping track of your medications?
       _____ Yes _____ No

27. How confident are you that you can control and manage most of your health problems?
    ____ Very confident
    ____ Somewhat confident
    ____ Not very confident

28. How often do you have trouble taking medicines the way you have been told to take them?
    ____ I always take them as prescribed
    ____ Sometimes I take them as prescribed
    ____ I seldom take them as prescribed
    ____ I do not have to take medicine

Clock Drawing must be completed in the office at time of visit.

28. Clock Drawing Test (A new standardized Medicare Assessment Tool.)
    1. Please draw a clock below
    2. Draw the clock face
    3. Draw the numbers in the correct position
    4. Draw the clock hands to show the time of 11:10

Patient Name: _____ DOB: _____

Thank you very much for completing your Medicare Wellness Assessment. Please give the completed form to your doctor or nurse.

Mood Scale (PHQ)

Over the <u>last two weeks</u>, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				

10. If you checked off any problems, 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	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Score: _____

POSITIVE/NEGATIVE

Plan:_____

_____

_____

I agree to release the results of this mood evaluation questionnaire to my referring heart doctor or family doctor.

_____ _____

Signature Date