NAME: ____________________________ DOB: __________________ TODAY'S DATE: _____________

# A WORD TO OUR PATIENTS ABOUT MEDICARE AND WELLNESS CARE

Dear Patient,

In order to allow for greater pricing transparency, we feel it is necessary to clarify the term "wellness care". We want you to receive wellness-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 may need. We want you to know about your Medicare benefits and maximize their usefulness.

The term "physical" is often used to describe wellness care. However, Medicare **does not** pay for traditional, head to toe physical. Medicare **does** pay for a wellness visit once a year to identify health risks and to help you reduce them.

**The Medicare Wellness Visit includes the following assessments:**

-Screening to detect depression, risk of falling, cognitive issues, and other problems.

-A measurement of your vital signs however, we will be performing a full exam as we feel that it is important to be diligent and thorough in your care.

-Recommendations for other wellness services and healthy lifestyles changes.

A wellness visit **does not** allow time to address **new or existing** health problems properly. These would qualify as separate services and require a longer appointment. Please let our scheduling staff know if you need the physician's help with a health problem or more pressing concerns, other than the wellness visit. We may need to schedule a separate appointment to complete the wellness at a later date. If performed, a separate charge applies to these services.

We hope that this helps clarify your Medicare wellness benefits.

# SCREENING AND PREVENTATIVE SERVICES

| Screening/Test | Please write the most recent dates for the following screenings: |
|---|---|
| Pneumococcal Vaccines (ex: Prevnar/ Pneumovax) | Date Completed: ___________________________ |
| Influenza Vaccine | Date Completed: ___________________________ |
| Shingles Vaccine | Date Completed: ___________________________ |
| COVID Vaccine | Date Completed: ___________________________ |
| RSV Vaccine | Date Completed: ___________________________ |
| TDAP Vaccine | Date Completed: ___________________________ |
| Lung Cancer Screening | Date Completed: ___________________________<br>Results Normal? YES NO UNSURE |
| Mammogram Screening | Date Completed: ___________________________<br>Results Normal? YES NO UNSURE |
| Bone Density Screening | Date Completed: ___________________________<br>Results Normal? YES NO UNSURE |
| Colorectal Cancer Screening | Date Completed: ___________________________<br>Results Normal? YES NO UNSURE |
| PAP Smear (females only) | Date Completed: ___________________________<br>Results Normal? YES NO UNSURE |
| PSA Screening (males only) | Date Completed: ___________________________<br>Results Normal? YES NO UNSURE |
| Eye Exam | Date Completed: ___________________________<br>Results Normal? YES NO UNSURE |

**List of Providers:**

Primary care Physician/Provider(s):

| Clinic/Provider Name | Location |
|---|---|
| | |
| | |

Specialist(s):

| Clinic/Provider Name | Location | Specialty |
|---|---|---|
| | | |
| | | |
| | | |

Alternative Medicine Providers: (chiropractor, acupuncturist etc.)

| Clinic/Provider Name | Location | Specialty |
|---|---|---|
| | | |
| | | |
| | | |

Preferred Pharmacy(s): Name/Location

| Pharmacy Name | Location |
|---|---|
| | |
| | |

Dentist:

| Name | Location |
|---|---|
| | |

# PHQ-9 Questionnaire

| Over the **last 2 weeks,** how often have you been bothered by the following problems? | Not at All | Several Days | More than half the days | Nearly everyday |
| --- | --- | --- | --- | --- |
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |
| Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| Poor appetite or overeating | 0 | 1 | 2 | 3 |
| Feeling bad about yourself- or that you are a failure or that you have let yourself or family down | 0 | 1 | 2 | 3 |
| Trouble concentrating on things such as reading or watching television | 0 | 1 | 2 | 3 |
| Moving or speaking so slowly that other people have Noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| Thought that you would be better off dead, or Hurting yourself | 0 | 1 | 2 | 3 |

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

# Medicare Wellness: Health Risk Assessment

## Living Situation

1) What is your living situation today?
   ___ I have a steady place to live
   ___ I have a place to live today, but I am worried about losing it in the future
   ___ I do not have a steady place to live (I am 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)
2) Think about the place you live. Do you 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

## Food

3) Within the past 12 months, are you worried that your food would run out before you got money to buy more?
   ___ Often true
   ___ Sometimes true
   ___ Never true
4) Within the past 12 months, the food you bought just did not last and you did not have money to get more.
   ___ Often true
   ___ Sometimes true
   ___ Never true

## Transportation

5) In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things need for daily living?
   ___ Yes
   ___ No

## Utilities

6) In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?
   ___ Yes
   ___ No
   ___ Already shut off

**Safety**

Because violence and abuse happen to a lot of people and affects their health, we are asking the following questions:

7) How often does anyone, including family and friends, physically hurt you?
   ___ Never (1) ___ Rarely (2) ___ Sometimes (3) ___ Fairly Often (3) ___ Frequently (4)
8) How often does anyone, including family and friends, insult or talk down to you?
   ___ Never (1) ___ Rarely (2) ___ Sometimes (3) ___ Fairly Often (3) ___ Frequently (4)
9) How often does anyone, including family and friends, threaten you with harm?
   ___ Never (1) ___ Rarely (2) ___ Sometimes (3) ___ Fairly Often (3) ___ Frequently (4)
10) How often does anyone, including family and friends, scream or curse at you?
   ___ Never (1) ___ Rarely (2) ___ Sometimes (3) ___ Fairly Often (3) ___ Frequently (4)
11) In general, would you say your health is:

   ___ Excellent ___ Very Good ___ Good ___ Fair ___ Poor

12) How have things been going for you during the past 4 weeks?
   ___ Very well; could hardly be better
   ___ Good and bad parts about equal
   ___ Very bad; could hardly be worse
13) How confident are you that you can control and manage most of your health problems/issues?
   ___ Very Confident ___ Somewhat confident ___ Not very confident
   ___ I do not have any health problems
14) How often in the **last 4 weeks,** have you been bothered by any of the following problems?

| | Never | Seldom | Sometimes | Often | Always |
|---|---|---|---|---|---|
| Falling or dizzy when standing | | | | | |
| Sexual problems or concerns | | | | | |
| Trouble eating well | | | | | |
| Teeth or denture problems | | | | | |
| Problems using the telephone | | | | | |
| Problems sleeping | | | | | |
| Tiredness or fatigue | | | | | |

15) Have you fallen two or more times in the past year? ___ Yes ___ No

16) Are you afraid of falling? Do you feel unsteady? ___ Yes ___ No

17) HOME SAFETY CHECKLIST
- Are entrance ways well lit? ___ Yes ___ NO
- Are sidewalks/entrance ways maintained? ___ Yes ___ No
- Is a carbon monoxide detector installed? ___ Yes ___No
- Are smoke detectors installed? ___ Yes ___ No
- Are all medicines kept in original containers with original labels intact?
  ___ Yes ___ No
- Do you throw out all unidentified or out of date medications? ___ Yes ___No

18) How often do you have trouble taking medications the way you have been told to take them?
___ I do not have to take medicine
___ I always take them as directed
___ Sometimes I take them as directed
___ I seldom take them as directed

19) Do you have difficulty driving your car?
___ Yes, often ___ Sometimes ___ No ___ N/A – I do not use a car

20) Do you always fasten your seat belt when you are in a car?
___ Yes, always ___ Yes, sometimes ___ No

21) How often in the **last 4 weeks** have you experienced the following:

| | Never | Seldom | Sometimes | Often | Always |
|---|---|---|---|---|---|
| Straining to understand conversation | | | | | |
| Trouble hearing in a noisy background | | | | | |
| Misunderstanding what others are saying | | | | | |

22) During the **last 4 weeks,** how much have you been bothered by feelings of anxiety, depression, irritability or sadness?
___ Not at all ___ Slightly ___ Moderately ___ Extremely

23) During the **last 4 weeks,** has your physical or emotional health limited your social activities with family and friends?
___ Not at all ___ Slightly ___ Moderately ___ Extremely

24) During the **last 4 weeks,** how much bodily pains have you generally had?
___ Not at all ___ Slightly ___ Moderately ___ Extremely

25) Do you have someone who is available to help you if you needed or wanted help?
___ Yes, as much as I want/need ___ Yes, some ___ No, not at all

26) 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

27) Because of any health problems, do you need the help of another person with shopping, preparation of meals, or house work?
____ Yes ____ No

28) Can you handle your own money without help?
____ Yes ____ No

29) During the **last 4 weeks,** did you exercise for about 20 minutes, 3 or more days a week?
___ Yes, most of the time
___ Yes, some of the time
___ No, I usually do not exercise
___ No, I am not currently exercising

30) When you exercise, how intensely do you typically exercise?
___ Light (stretching/slow walking)
___ Moderate (brisk walking)
___ Heavy (jogging/swimming)
___Very heavy (running/stair climbing)

31) Are you a smoker/tobacco user?
___ No-never ___ No-former ___ Yes, and I am interested in quitting ___ Yes, I am not ready to quit

32) In the **last 7 days,** how many of those days did you drink alcohol? _____ days

33) On the days that you drank alcohol, how often did you have 4 or more drinks?
___ Never ____ Once during the week ____ 2-3 times during the week

___ More than 3 times during the week

## CAGE ASSESSMENT

| Question | YES | NO |
|---|---|---|
| Have you ever felt you should **C**ut down on your drinking? | | |
| Have people **A**nnoyed you by criticizing your drinking? | | |
| Have you ever felt bad or **G**uilty about your drinking? | | |
| Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)? | | |
| **TOTAL** | | |
| **Scoring:** Item responses on the CAGE are scored 0 or 1, with a higher score an indication of alcohol problems. A total score of 2 or greater is considered clinically significant. | | |

**YAY YOU ARE DONE!**

**Thank you for completing this Medicare Wellness Health Risk Assessment** 😊

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

# Physician Orders for Life-Sustaining Treatment (POLST)-Florida

Follow these orders until orders are reviewed. These medical orders are based on the patient's **current** medical condition and preferences. Any section not completed does not invalidate the form and implies full treatment for that section. With significant change of condition new orders may need to be written.

| Patient Last Name | Patient First Name | Middle Int. |
| --- | --- | --- |
| Date of Birth: (mm/dd/yyyy) ___ ___ ___ | Gender ☐ M ☐ F | Last 4 SSN: ☐ ☐ ☐ ☐ |

**If the patient has decision-making capacity, the patient's presently expressed wishes should guide his or her treatment**

## A — Check One

**CARDIOPULMONARY RESUSCITATION (CPR): Patient is unresponsive, pulseless, and not breathing.**

☐ **Attempt Resuscitation/CPR**

☐ **Do Not Attempt Resuscitation/DNR**

**When not in cardiopulmonary arrest, follow orders in B and C.**

## B — Check One

**MEDICAL INTERVENTIONS: If patient has pulse and is breathing.**

☐ **Full Treatment – goal is to prolong life by all medically effective means.**
In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and /or intensive care unit if indicated.
**Care Plan: Full treatment including life support measures in the intensive care unit.**

☐ **Limited Medical Interventions – goal is to treat medical conditions but avoid burdensome measures**
In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP).
**Transfer to hospital if indicated. Generally avoid the intensive care unit.**
**Care Plan: Provide basic medical treatments.**

☐ **Comfort Measures Only (Allow Natural Death) – goal is to maximize comfort and avoid suffering**
Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location. Consider hospice or palliative care referral if appropriate.**
**Care Plan: Maximize comfort through symptom management.**

**Additional Orders:**______________________________

## C — Check One

**ARTIFICIALLY ADMINISTERED NUTRITION: Offer food by mouth if feasible.**

☐ **Long-term artificial nutrition by tube**.

☐ **Defined trial period of artificial nutrition by tube.**

☐ **No artificial nutrition by tube.**

Additional Instructions: ______________________________

## D — Check One

**HOSPICE or PALLIATIVE CARE (complete if applicable) - consider referral as appropriate**

| ☐ Patient/Resident Currently enrolled in Hospice Care<br>Contact:______________ | ☐ Patient/Resident Currently enrolled in Palliative Care<br>Contact:______________ | ☐ Not indicated or refused |
| --- | --- | --- |

## SIGNATURES

| Print Physician Name | MD/DO License # | Phone Number |
| --- | --- | --- |
| Physician Signature **(mandatory)** | Date | |
| Print Patient/Resident or Surrogate/Proxy Name | Relationship (write 'self' if patient) | |
| Patient or Surrogate Signature **(mandatory)** | Date | |

SEND FORM WITH PATIENT WHENEVER TRANFERRED OR DISCHARGED

Use of original form is strongly encouraged. Photocopies and facsimiles of completed POLST are legal and valid.

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

| E<br>Check All That Apply | DOCUMENTATION OF DISCUSSION: | | |
|---|---|---|---|
| | ☐Patient (Patient has capacity) | ☐Health Care Representative or surrogate | |
| | ☐Parent of minor | ☐Court-Appointed Guardian | ☐Other (proxy) |

Other Contact Information

| Name of Guardian, Surrogate or other Contact Person | Relationship | Phone Number/Address | |
|---|---|---|---|
| | | | |
| Name of Health Care Professional Preparing Form | Preparer Title | Phone Number | Date Prepared |
| | | | |

## Directions for Health Care Professionals

### Completing POLST

- Must be completed by a health care professional based on medical indications, a discussion of treatment benefits and burdens, and elicitation of patient preferences.
- POLST must be signed by a MD/DO to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- POLST must be signed by patient/resident or healthcare surrogate/proxy to be valid.

### Using POLST

- Any section of POLST not completed implies full treatment for that section.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid.
- A semi-automatic external defibrillator (AED) should not be used on a person who has chosen “Do Not Attempt Resuscitation.”
- Oral fluids and nutrition must always be offered if medically feasible.
- When comfort cannot be achieved in the current setting, the person, including someone with “comfort measures only,” should be transferred to a setting able to provide comfort, such as a hospice unit.
- A person who chooses either “comfort measures only” or “limited additional interventions” should not be entered into a Level I trauma system.
- An IV medication to enhance comfort may be appropriate for a person who has chosen “Comfort Measures Only.”
- A person who desires IV fluids should indicate “Limited Interventions” or “Full Treatment.”
- A person with capacity or the surrogate/proxy (if patient lacks capacity) can revoke the POLST at any time and request alternative treatment.

### Reviewing POLST

This POLST should be reviewed periodically and a new POLST completed if necessary when:

(1) The person is transferred from one care setting or care level to another, or
(2) There is a substantial change in the person’s health status, or
(3) The person’s treatment preferences change.

**To void this form, draw line through sections A through D on page 1 and write “VOID” in large letters.**

### Review of this POLST Form

| Review Date | Reviewer | Location of Review | Review Outcome |
|---|---|---|---|
| | | | ☐ No Change<br>☐ Form Voided ☐ New form completed |
| | | | ☐ No Change<br>☐ Form Voided ☐ New form completed |
| | | | ☐ No Change<br>☐ Form Voided ☐ New form completed |

**SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED**

**REVISED FORM (JULY 10,2015)**

# National POLST Model Form: A Portable Medical Order

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Health care providers should complete this form only after a conversation with their patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

**Patient Information.** **Having a POLST form is always voluntary.**

This is a medical order, not an advance directive. For information about POLST and to understand this document, visit: www.polst.org/form

Patient First Name: ______________________________

Middle Name/Initial: ______________ Preferred name: ______________

Last Name: ______________________ Suffix (Jr, Sr, etc): __________

DOB (mm/dd/yyyy): ____/____/______ State where form was completed:______________

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-___ ___ ___ ___

## A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse and is not breathing.

Pick 1

☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** (Requires choosing Full Treatments in Section B)

☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B)

## B. Initial Treatment Orders. Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ **Full Treatments (required if choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

## C. Additional Orders or Instructions.

These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

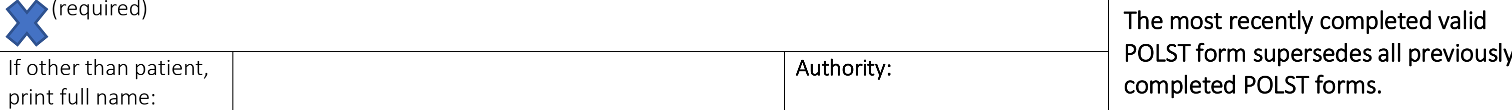
## D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes
☐ No artificial means of nutrition desired
☐ Trial period for artificial nutrition but no surgically-placed tubes
☐ Not discussed or no decision made (provide standard of care)

## E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.



X (required)

If other than patient, print full name: | Authority:

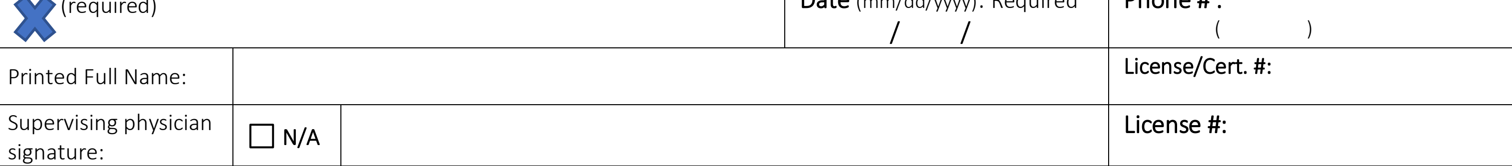
The most recently completed valid POLST form supersedes all previously completed POLST forms.

## F. SIGNATURE: Health Care Provider (eSigned documents are valid)

Verbal orders are acceptable with follow up signature.

I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge.
[Note: Only licensed health care providers authorized by law to sign POLST form in state where completed may sign this order]

X (required) | Date (mm/dd/yyyy): Required / / | Phone # : ( )



Printed Full Name: | License/Cert. #:

Supervising physician signature: ☐ N/A | License #:

A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire.

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**National POLST Model Form – Page 2** *******ATTACH TO PAGE 1*********

**Patient Full Name:**

## Contact Information (Optional but helpful)

Patient's Emergency Contact. (Note: Listing a person here does **not** grant them authority to be a legal representative. Only an advance directive or state law can grant that authority.)

| Full Name: | ☐ Legal Representative<br>☐ Other emergency contact | Phone #:<br>Day: ( )<br>Night: ( ) |
|---|---|---|
| Primary Care Provider Name: | | Phone:<br>( ) |

☐ Patient is enrolled in hospice — Name of Agency:
Agency Phone: ( )

## Form Completion Information (Optional but helpful)

| Reviewed patient's advance directive to confirm no conflict with POLST orders:<br>(A POLST form does not replace an advance directive or living will) | ☐ Yes; date of the document reviewed:______________________<br>☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart)<br>☐ Advance directive not available<br>☐ No advance directive exists |
|---|---|

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Court Appointed Guardian ☐ Parent of Minor ☐ Legal Surrogate / Health Care Agent ☐ Other: ___________________________

| Professional Assisting Health Care Provider w/ Form Completion (if applicable):<br>Full Name: | Date (mm/dd/yyyy):<br>/ / | Phone #:<br>( ) |
|---|---|---|

This individual is the patient's: ☐ Social Worker ☐ Nurse ☐ Clergy ☐ Other:

## Form Information & Instructions

- **Completing a POLST form**:
  - Provider should document basis for this form in the patient's medical record notes.
  - Patient representative is determined by applicable state law and, in accordance with state law, may be able execute or void this POLST form only if the patient lacks decision-making capacity.
  - Only licensed health care providers authorized to sign POLST forms in their state or D.C. can sign this form. See www.polst.org/state-signature-requirements-pdf for who is authorized in each state and D.C.
  - Original (if available) is given to patient; provider keeps a copy in medical record.
  - Last 4 digits of SSN are optional but can help identify / match a patient to their form.
  - If a translated POLST form is used during conversation, attach the translation to the signed English form.
- **Using a POLST form:**
  - Any incomplete section of POLST creates no presumption about patient's preferences for treatment. Provide standard of care.
  - No defibrillator (including automated external defibrillators) or chest compressions should be used if "No CPR" is chosen.
  - For all options, use medication by any appropriate route, positioning, wound care and other measures to relieve pain and suffering.
- **Reviewing a POLST form:** This form does not expire but should be reviewed whenever the patient:
  (1) is transferred from one care setting or level to another;
  (2) has a substantial change in health status;
  (3) changes primary provider; or
  (4) changes his/her treatment preferences or goals of care.
- **Modifying a POLST form:** This form cannot be modified. If changes are needed, void form and complete a new POLST form.
- **Voiding a POLST form:**
  - **If a patient or patient representative (for patients lacking capacity) wants to void the form**: destroy paper form and contact patient's health care provider to void orders in patient's medical record (and POLST registry, if applicable). State law may limit patient representative authority to void.
  - **For health care providers**: destroy patient copy (if possible), note in patient record form is voided and notify registries (if applicable).
- **Additional Forms.** Can be obtained by going to www.polst.org/form
- As permitted by law, this form may be added to a secure electronic registry so health care providers can find it.

| State Specific Info | For Barcodes / ID Sticker/Medical Record # |
|---|---|

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