CareSource™

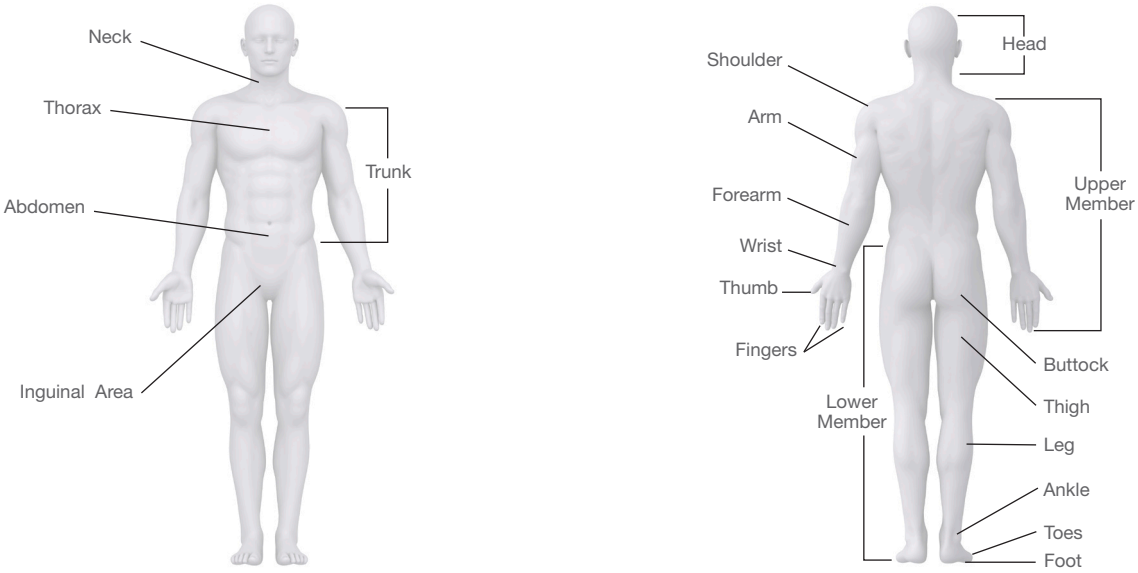
Care Of Older Adults Assessment Form

PHYSICIAN NAME: _____

DATE:____/____/____ PATIENT:_____ DOB:____/____/____ ID#:_____

PAIN ASSESSMENT

Please draw where the patient's primary pain is located using the diagram below:



Pain: YES NO **Location:** _____

Comments: _____

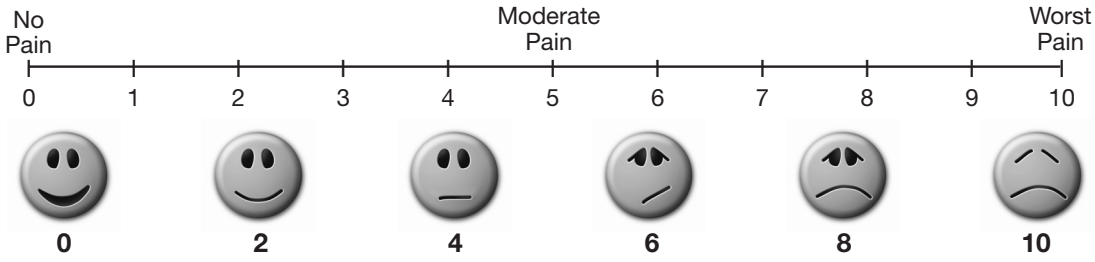
_____

Treatment Plan:

Medication(s)_____

Under Pain Management: Dr _____

Mark the level of Pain



Physician's Signature: _____

Comments:_____

PAIN ASSESSMENT: *CPT Cat II – 1125F, 1126F*

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Care Of Older Adults Assessment Form

PHYSICIAN NAME: _____

DATE:____/____/____ PATIENT:_____ DOB:____/____/____ ID#:_____

FUNCTIONAL ASSESSMENT (circle those that apply)

Cognitive Status: Excellent; Diminished; Dementia; Alzheimer's; Parkinson; Other:_____

Ambulatory Status: Excellent; Good; Fair; Walks with cane; Uses wheel chair or scooter; Able to climb stairs; Needs assistance; Amputation R/L – AKA; Prosthetic devices:_____

SENSORY ABILITY: (circle all that apply)

Hearing: Excellent; Good; Fair; Poor; Deaf; Hearing Aids or Device:_____

Vision: Excellent; Good; Poor; Uses Glasses; Uses contacts; Cataract(s); Glaucoma; Macular Degeneration; DM Retinopathy; Blind

Speech: Excellent; Good; Poor; Verbal apraxia; Aphasia; Dysphonia; Ill-fitting dentures; Abnormal tongue/lip movements

Touch: Intact; Decreased sensitivity (hot/cold); Numbness

Smell/Taste: No problem, Some changes:_____

ACTIVITIES OF DAILY LIVING – ADL: (circle those that apply)

Does the patient need help with: Grooming; Dressing; Bathing; Housework; Preparing meals; Feeding; Shopping; Toilet Use; Continent (Bowel & Bladder) Other: _____

ADVANCE CARE PLANNING

Does the patient have: **Advanced Directive** (Y) (N) **Living Will** (Y) (N) **Surrogate Decision Letter** (Y) (N)

Date discussed with patient/family member: _____/_____/_____ **Copy or documented in chart:** (Y) (N)

Physician's Signature: _____

Comments:_____

FUNCTIONAL STATUS ASSESSMENT: *CPT CAT II – 1170* **ADVANCE CARE PLANNING:** *CPT CAT II – 1157F, 1158F HCPCS - S0257*

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Care Of Older Adults Assessment Form

PHYSICIAN NAME: _____

DATE:____/____/____ PATIENT:_____ DOB:____/____/____ ID#:_____

MEDICATION REVIEW/LIST (Indicate (Y) yes or (N) no)

Medication Review Completed: (Y) (N) **Medication List Completed:** (Y) (N)

_____

_____

_____

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_____

_____

_____

Physician's Signature: _____

Comments:_____

MEDICATION REVIEW: *CPT CAT II – 1160F*