Care of the Older Adult

As part of our commitment to improve the health outcomes for our patients, certain patients are required by CMS to have an annual assessment of their pain level and functional status. This outreach can be completed in the office or telephonically. Please use the results of the assessments to ensure your patient remains safe and healthy. Once the survey is finished, please include the completed form in the patient's chart and fax a copy to 818-672-8973. The completion of these assessments will help you to be a 5 STAR provider!

Advanced Care Planning

1) Do you have advanced directives or processes in place (circle one)? YES / NO
2) If life planning is in place, indicate which of the following the member has (circle one):
   Living Will / Health Care Surrogate / POLST / DPOH / NA / None of these
3) What is the code status of the member (circle one)?
   DNR / Partial Code / Full Code / Family or Member Undecided / Unknown
4) Was advanced care planning discussed? YES / NO
   Any follow-up needed? _____

Functional Status Assessment

1) Has the member had any falls in the last 6 months (circle one)? YES / NO
2) If member has had falls, how many? If none, then indicated "none." _____
3) Does the member have any weaknesses of the extremities that interferes with their self-care or motility (circle one)? YES / NO
4) In the following questions, indicate the level of ability of the member to self care (circle one for each):
   a. Dressing: Independent / Min Assist / Mod Assist / Max Assist / Totally Dependent
   b. Bathing: Independent / Min Assist / Mod Assist / Max Assist / Totally Dependent
   c. Toileting: Independent / Min Assist / Mod Assist / Max Assist / Totally Dependent
   d. Transferring: Independent / Min Assist / Mod Assist / Max Assist / Totally Dependent
   e. Eating/Feeding: Independent / Min Assist / Mod Assist / Max Assist / Totally Dependent

Pain Assessment

1) Do you have CHRONIC pain (circle one)? YES / NO
2) If the member has chronic pain, where is it located? _____
3) Pain origin, if different from the location of pain: _____
4) Pain Quality (circle one): Aching / Dull / Burning / Cramping / Crushing / Stabbing / Other: _____
5) What is the pain intensity prior to treatment (circle one, 0 being no pain, 10 being max pain)?
   0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
6) How often is the pain (circle one)? Constant / Daily but not constant / Less than daily
7) What are your associated symptoms (circle all that apply)?
   Loss of appetite / Diaphoresis / Nausea / Vomiting / Fatigue / Other: _____
8) What control measures are in place (circle all that apply)?
   Biofeedback / Heat Cold / Massage / Medication / Relax / Rest / TENS Unit / Music / Other: _____
9) What is your response to the control measures and your level of pain AFTER intervention (circle one, 0 being no pain, 10 being max pain)?
   0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Patient Name: _____ DOB: _____

Provider Name: _____

Provider Signature: _____ Date: _____