



Patient Name: _____ DOB: _____ Date: _____

Adult Assessment (Non-Medicare)

Patient Use	Office Use
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Preventive Care

<p>Date of last Colorectal Cancer Screening (Ages 45-75): Date: _____ Type of test: _____ Results: _____</p> <p>Female Patients <input type="checkbox"/> Date of last Mammogram: _____ Facility performed: _____ Ordering Provider: _____ Results: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Date of last Pap Smear (Ages 21-64): _____ <input type="checkbox"/> Date of last Chlamydia Testing (Ages 16-24 if sexually active): _____ If you are 67-85 years of age, have you suffered a fracture in the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, did you receive a bone mineral density test or prescription for a drug to treat osteoporosis in the six months after the fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Screening results documented and reviewed 3017F <input type="checkbox"/> Total Colectomy or Colorectal Cancer G9711</p> <p><input type="checkbox"/> Ages 40-74 every 27 months 77062 <input type="checkbox"/> Bilateral mastectomy Z90.13 <input type="checkbox"/> Absence of right breast Z90.11 <input type="checkbox"/> Absence of left breast Z90.12</p>
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Disease Management

Have you previously been diagnosed with Hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No	Systolic: <input type="checkbox"/> < 130 3074F <input type="checkbox"/> 130-139 3075F Diastolic: <input type="checkbox"/> < 80 3078F <input type="checkbox"/> 80-89 3079F
Are you currently prescribed and taking a statin (cholesterol) medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Medication: _____	<input type="checkbox"/> Member on statin therapy G9664
Have you been diagnosed with Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you see a diabetic specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of Specialist: _____ When was your last dilated retinal Eye Exam Date? _____ Provider: _____	

Social Determinants of Health (SDOH)

What is the highest grade level completed? __ Elementary __ Jr High School __ High School __ College
 What is your current employment status? __ Employed __ Retired __ Un-employed __ Stay at home
 What is your current living situation? __ Live at home __ Live with family member __ Live in shelter/car/tent
 Are there any concerns at home, e.g., utilities, bugs, leaks, etc...? __ Yes __ No
 Can you comfortably purchase necessities, such as medication? __ Yes __ No
 Do you worry that your food will run out before you have money to buy more? __ Never __ Sometimes __ Always
 What form of transportation do you use? __ Walk __ Car __ Bicycle __ City Bus __ Uber/Lyft __ Rely on others
 Who is your current support system? __ Family __ Friend __ Clergy __ Therapist __ Other
 Do you have any personal safety concerns? Yes/No
 Please list other areas that you may need assistance with, if any: _____

Annual Depression Screening PHQ-9

Over the last 2 weeks, how many days have you been bothered by any of the following:	Not at all	Several days	More than half	Nearly every day
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 have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV	0	1	2	3
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	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Declined **G8433** Bipolar disorder **G9717** Negative **G8510** Positive and follow-up plan documented **G8431**
TOTAL

How difficult have those 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

Patient Signature: _____ Date: _____



FOR OFFICE USE ONLY

Additional Annual Wellness Visit Coding Guidance

Patient Name: _____ DOB: _____ Date: _____

Colorectal Screening Codes	Mammogram/Pap/Chlamydia Codes
<ul style="list-style-type: none"> <input type="checkbox"/> Fecal Occult Blood Test (e.g., gFOBT, FIT every year) <input type="checkbox"/> Stool DNA Test (e.g., Cologuard every 3 years) <input type="checkbox"/> Flexible Sigmoidoscopy (every 5 years) <input type="checkbox"/> Computed Tomography Colonography (every 5 years) <input type="checkbox"/> Colonoscopy (every 10 years) <input type="checkbox"/> Screening results documented and reviewed - 3017F <input type="checkbox"/> Exclusion: History of Total Colectomy or Colorectal Cancer - G9711 	<ul style="list-style-type: none"> <input type="checkbox"/> Mammogram Ages 40-74 every 27 months <input type="checkbox"/> Pap smear lab codes within the last 3 years 88141, P3000, G0147, G0476, 87624 <input type="checkbox"/> Hysterectomy Z90.710, Acquired absence of both cervix and uterus <input type="checkbox"/> Chlamydia Lab Testing codes once a year 87110, 87270, 87320, 87490, 87810
Annual Wellness Visit Billable Codes	Patients with Diabetes Codes
<p>Annual Wellness Visit (AWV) New Patient</p> <ul style="list-style-type: none"> <input type="checkbox"/> 99385 – 18-39 years old <input type="checkbox"/> 99386 – 40-64 years old <input type="checkbox"/> 99387 – 65 years and older <p>Annual Wellness Visit (AWV) Established Patient</p> <ul style="list-style-type: none"> <input type="checkbox"/> 99395 – 18-39 years old <input type="checkbox"/> 99396 – 40-64 years old <input type="checkbox"/> 99397 – 65 years and older 	<p>Date: _____ A1C Level: _____</p> <ul style="list-style-type: none"> <input type="checkbox"/> A1C < 7.0% - 3044F <input type="checkbox"/> A1C ≥ 7.0% - < 8.0% - 3051F <input type="checkbox"/> A1C ≥ 8.0% - ≤ 9.0% - 3052F <p>Screening for Diabetic Retinal Disease</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with retinopathy 2022F <input type="checkbox"/> Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; no retinopathy 2023F <p>Kidney Health Evaluation</p> <ul style="list-style-type: none"> <input type="checkbox"/> Estimated Glomerular Filtration Rate Lab Test: 80047; 80048; 80050; 80053; 80069; 82565 <input type="checkbox"/> Quantitative Urine Albumin Lab Test: 82043 <input type="checkbox"/> Urine Creatinine Lab Test: 82570 <input type="checkbox"/> Urine Albumin Creatinine Ratio Lab Test: 82570

SDOH Z Codes

Diagnosis Description	Z Code
Problems related to education and literacy	Z55
Problems related to employment and unemployment	Z56
Occupational exposure to risk factors	Z57
Problems related to physical environment	Z58
Problems related to housing and economic circumstances	Z59
Problems related to social environment	Z60
Problems related to upbringing	Z62
Other problems related to primary support group, including family circumstances	Z63
Problems related to psychosocial circumstances	Z64, Z65