MEDICARE EXAMINATION CONSENT

Dear Patient:

Our records indicate you have been scheduled today for a "**Physical Exam.**" These exams are also known by, but not limited to the following terms:

PPE: Initial Patient Assessment Exam – "Welcome to Medicare Visit"

This is a **one time benefit** during the **first year of Medicare coverage.** It is a review and consultation visit only, and *does not include a routine full physical exam.* This visit consists of a review of your pre-completed information forms, vital signs, visual acuity testing and a written checklist for education, counseling and referral for tests and services covered under the Medicare Preventative Benefits.

This is the service I am requesting for today _____

Please sign and date

Annual Wellness Visit

This visit is similar to the Initial Welcome to Medicare Visit. This can only be done **AFTER** the 1st year of Medicare eligibility, and **MUST NOT** be done within 12 mos. of having received the Initial Welcome to Medicare Visit. It is comprised of a health risk assessment and a personalized prevention plan with development of a yearly schedule for appropriate preventative services. Required elements of the visit are:
Review of medical and family history, prescribed medication review, listing and review of all physician providers currently seen, measurement of vital signs, observation for detection of cognitive impairment, screening for depression, and a functional ability assessment. Also included is delineation of risk factors with plans for intervention and referral for health education or preventive services. This is **NOT** meant to take place of a Complete/Routine Physical Exam. Follow up for management of chronic problems will be done at a separate visit. This will ensure sufficient time to discuss services available to promote you health.

This is the service I am requesting for today_____

Please sign and date

Complete Physical Exam/Routine Exam

This is a non-covered benefit under Medicare. This visit will not include a discussion or follow up of any chronic illness which must be scheduled for a separate visit so as to ensure sufficient time to discuss services available to promote your health.

Date of last Complete/Routine Physical_____ Date of last Prostate Exam_____

Date of last Pap/Pelvic/Breast Exam _____

This is the service I am requesting for today _____

Please sign and date

I understand and acknowledge the above descriptions of the different types of exams that are offered and I consent to the service I have checked, signed and dated.

_____ _____

Patient Name Date of Birth Date

Patient Name: _____ Date of Birth:_____ Date of Service:_____

ADVANCED CARE PLANNING (Optional for AWV)

Advance directives are legal documents that allow you to put in writing what kind of health care you would want if you were too ill to make decisions for yourself. Specifically, a Medical Durable Power of Attorney allows you to name someone to make decisions about you medical care if you can no longer speak for yourself. Another document called a Living Will (in Colorado this is sometimes called the Colorado Declaration) allows you to state your wishes about medical care in the event you develop a terminal condition or are in a persistent vegetative state. If you do already have these documents, it is important that you bring a copy for your chart.

Do you have a Medical Power of Attorney? Yes / No

If so, please list the name of your medical power of attorney

Name: _____

Do you have a Living Will? Yes / No

For those who have completed paperwork for Advanced Directives, have you expressed that you chose to be a DNR (Do Not Resuscitate)? Yes / No

(This means you do not wish for medical professionals to perform CPR on you in the event your heart should stop.)

For those who have not completed Advanced Directives would you like further information on how to do so? Yes/ No

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DOB: _____ DATE:_____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

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 _____

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