Care of the Older Adult

As part of Centers for Medicare and Medicaid Services' (CMS) 5 STAR program, certain patients are required to have an annual screening of their functional status, health assessment and medication reconciliation. Please assist us by completing the questions below.

Physician: Once completed, please fax back at 818-672-8973. This allows us to update the system on your behalf to help you be a 5 STAR physician. In addition, please keep the completed form in the patient's chart.

Advanced Care Planning

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

Functional Status Assessment

1) Have you had any falls in the last 6 months (circle one)? YES / NO
2) If you have had falls, how many? If none, then indicated "none," ______
3) Do you have any weaknesses of the extremities that interferes with their self-care or motility (circle one)? YES / NO

In the following questions, indicate the level of your ability 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 you have 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) How do you treat the pain (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: ____________________________________ Patient DOB: ____________

Person who completed form: ____________________________ Date: ________________

Provider Name: ____________________________________ M.D. / D.O. / N.P. / P.A.

Provider Signature: ________________________________ M.D. / D.O. / N.P. / P.A.