Sumana Ketha M.D.
Board certified in Internal Medicine

DFW Primary Care PLLC
2925 Skyway Cir N Irving, TX 75038
PH#: (972) 639-5838, FAX#: (972) 791-8211
Email: accounts@dfwprimary.com

DFW Primary Care PLLC

(This section needs to be filled by patient)

PATIENT INFORMATION

*Patient Name: _____ *DOB: _____ Date: _____

*Address: _____ *City: _____

*Zip Code: _____ *State: _____

*Marital Status *(check one)*: ☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed ☐ Other

*Home Phone: _____ *Mobile Phone: _____ Allow SMS: Yes ☐ No ☐

Email Address: _____ Allow Email: Yes ☐ No ☐

Allow Patient Portal: Yes ☐ No ☐

* Emergency Contact Person Name: _____ *Phone: _____

Occupation: _____

Employer: _____

Drivers/ID Number: _____ *Social Security Number: _____

Language: _____ Ethnicity: _____

Preferred Pharmacy Name: _____

Preferred Company Lab Name: _____

Current Home Health Agency: _____ Admission Date : _____

Current inpatient facility : _____ Admission Date : _____

INSURANCE INFORMATION

*Primary Insurance Provider: _____ Secondary Insurance Provider: _____

*Plan Name: _____ Plan Name: _____

*Policy Number: _____ Policy Number: _____

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INTERNET BASED PATIENT PORTAL AUTHORIZATION

Starting November 1, 2015, DFW Primary Care PLLC is pleased to offer our Internet - based HIPPA compliant patient portal which will allow us to communicate with you securely via the Internet. We can establish two-way communication with you which will allow you to send us Internet – based communications, reply to our Internet communications to you, request prescription refills and referrals, schedule appointments, and give you any – time access to and the ability to print and/or download your finalized medical records from your DFW Primary Care PLLC. All Internet communications will be done through our patient portal to allow the utmost in privacy and confidentiality.

The first step is to provide us with a valid email address, and we will create a Patient Portal account for you. A message will be sent to your email address containing the URL (Internet address) for our Patient Portal (DFW Primary Care PLLC /Patients). It will also contain a username password (which you should customize for security) which you must use to log in to the Portal. A document called "How to use the Patient Portal" is posted on our website and also can be requested from our office. Please note that our practice website (www.dfwprimary.com) has a different Internet address than the Patient Portal but that there will be link on our website to access the Patient Portal.

By signing below, you indicate that you are giving DFW Primary Care PLLC. Permission to send emails or text messages to you notifying you of communications that will be available and accessible only through the secure, HIPPA compliant Patient Portal accessed by your own unique username and password. The communications may involve all aspects of you care including test results, need for follow-up and appointment reminders, billing and insurance issues, answers to questions and concerns you have raised with our staff etc.

*Patient Signature: _____ *Date: _____

Note: open in adobe acrobat to place electronic signature

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PATIENT AGREEMENT

I_____(Name)_____dated, do hereby consent and acknowledgment my agreement to the terms set forth in the HIPAA and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward. In addition to the above, a condition of being admitted for treatment as a outpatient of DFW Primary Care PLLC, I acknowledge the following consent of treatment, authorization to release medical records, assignment of insurance

benefits, Medicare/ Medicaid assignment of benefits, frequency of Right/ Hotlink Procedure, and additional understandings. I understand by knowledgement of this agreement, I must abide by the rules reviewed above and that failure to abide by these agreements will result in termination of medication prescriptions and possibly termination of services from my doctor and her practice.

Condition of Admittance: As a condition of being admitted for treatment as an outpatient to the DFW Primary Care PLLC, I agree to the following:

1. Consent of Treatment: I voluntarily request and consent to treatment by DFW Primary Care PLLC I authorized the treating Physician and their Assistants and DFW Primary Care PLLC to perform medical treatment and technical procedures, to administer drugs, and to render care as their judgment may indicate to be necessary or advisable. I understand the services provided me by DFW Primary Care PLLC are provided by doctors or physician assistants, podiatrist, psychologist, psychiatrist, physical therapist, and nurse practitioners. DFW Primary Care PLLC will maintain records of the services you receive. His consent only covers your protected health information created why you are a patient at DFW Primary Care PLLC. Your protected health information pertains to your diagnosis and a treatment by DFW Primary Care PLLC including but not limited to information concerning medical illness (except for psychotherapy notes) use of alcohol or drugs or communicable diseases such as human immunodeficiency virus (HIV) and acquired immune deficiency syndrome

   (AIDS) Laboratory test results medical history treatment history treatment progress or any other such related information. By signing this form, you consent to DFW Primary Care PLLC use and/or disclosure of pre-existing health information about how DFW Primary Care PLLC and physicians on its medical staff may use and or disclose protected health information about your treatment, payment, health care questions and as otherwise allowed by law.
   Consent for any major surgical procedures or other procedures by physicians/ surgeons requiring additional consent will be requested by the physician

   performing such and shall be obtained preceding with exception for those procedures administered necessary for extreme life-saving emergencies.

2. Authorization to Release Medical Information: I authorize DFW Primary Care PLLC any treating physician to finish requested information from patient medical records to

   a. Any insurance company or third-party payer for the purpose of payment on the account of DFW Primary Care PLLC or a treating Medical Practice.
   b. Any other persons or entities financially responsible for the patient's treatment
   c. Representatives of government agencies in accordance with law such information includes but is not limited to information about communicable diseases such as AIDS. I authorize release of information from or the review of the patient records for medical audit. Affiliation reviews or quality assistance reviews I authorize DFW Primary Care PLLC to release information from our copies of the patient medical records to the referring physician or to any Skilled Nursing Facility or health-care facility which I may be transferred.
   d. Lastly only that designated person listed are authorization to read or have access to or be included to Patient Care conference or discuss on my behalf.

3. Assignment of Insurance Benefits: I assign to DFW Primary Care PLLC All rights to file and interest in any payment due me for services described herein as provided in an insurance policy or employee Benefit Plan. I further assign All rights to payment due to use The Physician Services Under said policies to positions which provide treatment for me while I'm a DFW Primary Care PLLC patient. I understand I am responsible for providing to DFW Primary Care PLLC all insurance information available

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at the time of outpatient visit to allow for verification. I agree to pay any amount due to physician that are not covered by insurance. I'm responsible to inform the agency of any changes to my insurance plan

4. Medicare/ Medicaid assignment of benefits: I certify that the information given to me by applying for payment under the Social Security Act information required for filing a Medicare claim I request that payment of authorized benefit to be made out on my behalf, I assign benefits payable for services to The Physician organization submitting a claim to Medicare for me. Medicaid: I understand that Medicaid recipients are responsible for payment of any medical services receive that are beyond the services of the Medicaid Program as determined by the Texas Department of Health and Human Services all such payments are due and payable at the time of services rendered.
5. Frequency Rights/Hotline Procedure: I understand that Dr. Sumana Ketha or her Designee Physician or Assigned Physician Assistants / Nurse Practitioners will be my visiting doctor. I understand my patient Bill of Rights. I have been notified of my rights to voice complaint and may direct that complaint with the Secretary of the Health and Human Services (Dept. Of Health and Human Services at 200 Independence Ave, SW. Washington D.C. 20201).

I may also direct complaint to the Management of the Practice to do the investigation of the complaint which week be initiated within 10 calendar days and resolved within 30 calendar days receipt. I understand that it is my right and responsibility to be involved in my case and I will be informed as to the nature and purpose of any abuse, neglect or exploitation of agency testing policy and hazardous disposal. I have been advised verbally and in writing my right to the collection of information and the Privacy Act HIPPA. I have received the Notice of Privacy Practices and the consent of agency's use and/ or disclosure of protected health information for the patient. I also acknowledge that I have read and received a copy of the patients' Bill of rights.

6. Additional Understandings:
   a. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me with respect to the results of any examination or treatment to be performed by DFW Primary Care PLLC.
   b. I authorize DFW Primary Care PLLC to use its discretion to retain or dispose of any issue removed during any treatment or diagnosis procedure.
   c. All accounts over 60 days old will be considered delinquent and payable immediately. If payment is not received by 30 days, the account will be referred to an outside collection agency or attorney's office and will be reported to the credit bureau. The patient or responsible party will be responsible for all attorney and/ or collection agency fees and cost.

Medication Use Agreement

I, the above signed, understand that I have hindrances that have not been adequately controlled with other medications and my function is limited by these hindrances. I understand that the intent of the medication is to increase my ability to do more, through the medication is unlikely to eliminate the hindrances. I will take the medication only as prescribed; I will not take any sedatives such as alcohol or other pain medications without the authorization of doctor. I understand that the medication will be prescribed only by Dr. Ketha/ DFW Primary Care PLLC / NP/PA's and only by the agreed upon schedule. Prescriptions will only be provided during regularly scheduled appointments. Refills will never be given over the telephone. I will not seek or accept medications from family or friends, and any licit street drugs. Medication refills will be provided as written prescription only. No refills will be given prior to the next appointment date. If I do not keep my appointment, I will not receive refills. Two (2) appointment cancellations with less that a workday notice or two (2) no-show appointments may constitute grounds for immediate termination of this agreement. I understand that my doctor under no obligation to provide these medications to me, and that he/she reserves the right to discontinue these medications at any time at Dr. Ketha's discretion. I agree to cooperate with random drug testing, which may be requested at any time. If I refuse, I understand the medications will be stopped. I understand that lost or stolen medication will not be refilled under any circumstances. It is my responsibility and duty to secure and protect my medications and keep out of the reach of children. A copy of the police report will be required for any lost or stolen narcotic prescriptions. My doctor will send a report of my care and copy of this agreement when a referral is made. In addition to the above agreements, I accept the right of my doctor's medical staff to terminate this agreement for any of the following reasons:

1. I seek or obtain medication from another source other than my doctor.
2. I give, sale, or an any way distribute prescribed medications to any other person(s),

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3. I In any way attempt to forge or alter a prescription,
4. My medical condition declines to the point at which, in the judgment of my doctor confirms therapy with the medication presents a larger threat to my wellbeing or safety.
5. There is evidence that I am no longer receiving a reasonable therapeutic benefit from the medication, or my doctor, determines that I am no longer a good candidate to continue medication(s).

I agree to fill my prescriptions only at the pharmacy I listed below. If I change pharmacies, I will contact my doctor's office and provide them with name, address, and phone number of the new pharmacy. Under no circumstances will I obtain medications from more than one pharmacy at a time. To verify appropriate medication use, my doctor's office will provide any chosen pharmacy with a copy of this agreement.

NOTICE OF PRIVACY PRACTICES [DFW Primary Care PLLC 2925 Skyway Circle N Irving, Tx. 75038][Sumana Ketha, M.D. Phone 972-639-5838]

Effective Date (April 14, 2003) THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice property. We are required by law to maintain the privacy of protected health Information, to provide Individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health Information. This notice describes how we may use and disclose your medical Information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

1. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.]
2. Sign in Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
3. Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative, or another person responsible for your care about your location, your general condition or, unless you had Instructed us otherwise, In the event of your death.
4. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you.
5. Changes to this Notice of Privacy Practices We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received.
6. Complaints about this Notice of Privacy Practices or how this medical practice handles your health Information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.
7. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us.

I the undersigned do hereby agree to the terms, conditions, and rules set forth in the Conditions of Admittance, Medication Use Agreement, and HIPAA Information sections. Furthermore, I certify all the information I provide is accurate and complete. I shall notify the clinic should any Information change in the future. I understand that I am an Individual and treatment for me is on an Individual basis. I recognize I may revoke this consent at any time in writing except of the extent that period has been taken in reliance on It. I have read this agreement and understand what Information will be used or disclosed, who may use and disclose the information and the recipient(s) of that information.

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CONSENT AGREEMENT

By signing this Agreement, you consent to DFW Primary Care PLLC

(referred to as "Provider), providing chronic care management services (referred to as "CCM Services) to you as more fully described below.

CCM Services are available to you because you have been diagnosed with two (2) or more chronic conditions which are expected to last at least twelve (12) months, and which place you at significant risk of further decline. CCM Services include 24-hours-a-day, 7-days-a-week access to a health care provider in Provider's practice to address acute chronic care needs; systematic assessment of your health care needs; processes to assure that you timely receive preventative care services; medication reviews and oversight; a plan of care covering your health issues; and management of care transitions among health care providers and settings. The Provider will discuss with you the specific services that will be available to you and how to access those services.

Provider's Obligations.
When providing CCM Services, the Provider must:

- Explain to you (and your caregiver, if applicable), and offer to you, all the CCM Services that are Applicable to your conditions.
- Provide to you a written or electronic copy of your care plan.
- If you revoke this Agreement, provide you with a written confirmation of the revocation, stating the effective date of the revocation

Beneficiary Acknowledgment and Authorization.
By signing this Agreement, you agree to the following:

- You consent to the Provider providing CCM Services to you,
- You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- You acknowledge that only one practitioner can furnish CCM Services to you during a thirty (30)-day period.
- You understand that cost-sharing will apply to CCM Services, so you may be billed for a portion of CCM Services even though CCM Services will not Involve a face-to-face meeting with the Provider.

Beneficiary Rights.
You have the following rights with respect to CCM Services:

- The Provider will provide you with a written or electronic copy of your care plan.
- You have the right to stop CCM Services at any time by revoking this Agreement effective at the end of the then-current thirty (30)-day period of services., You may revoke this agreement verbally (by calling Jori in writing (to of your revocation, the Provider will give you written confirmation (including the effective date) of revocation.

*Patient Signature: _____ *Date: _____

Note: open in adobe acrobat to place electronic signature

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(This section needs to be filled by patient)

Patient Name:_____ DOB:_____ Date:_____

MEDICATIONS

Please list all medications, vitamins, home remedies etc.

Medication Name	Date Last Filled
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

PERSONAL / FAMILY / HISTORY

Medical Problem	Relationship	Medical Problem	Relationship
☐ Hypertension		☐ Congestive Heart Failure	
☐ Hyperlipidemia		☐ Stroke	
☐ Hypothyroidism		☐ Diabetes	
☐ Asthma / COPD		☐ Glaucoma	
☐ Depression/Anxiety		☐ Cancer	
OTHER:			

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Patient Name: DOB: Date:

MENTAL WELLNESS

During the past four weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue ?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

During the past four weeks, has your physical and emotional health limited your social activities with family, friends, neighbors, or groups?

☐ Not at all ☐ Slightly ☐ Moderately ☐ Quite a bit ☐ Extremely

THINKING ABILITY CHANGES

I have noticed a recent decline in my memory	☐ Yes	☐ No
Others (my friends and family) tell me I am forgetting things they tell	☐ Yes	☐ No
me My ability to concentrate seems to have declined recently	☐ Yes	☐ No
I have suffered recent losses that might hurt some of my thinking	☐ Yes	☐ No
abilities I get confused or easily distracted more than I used to	☐ Yes	☐ No

FALL RISK SCREENING

Have you fallen 2 or more times in the past 12 months? ☐ Yes ☐ No [1101F-no falls or 1 fall w/o injury]

Have you been injured in a fall in past 12 months? ☐ Yes ☐ No [1100F-two or more falls in 12 mo or fall w/ injury]

If you answered "Yes" to either of these questions, please complete the following questions.
If you answered "No" to BOTH questions, please go to the NEXT SECTION.

☐ Yes ☐ No 1) Have you fallen before or been injured because of a fall?
☐ Yes ☐ No 2) Do you feel weaker than you used to or have less strength in your arms and legs?
☐ Yes ☐ No 3) Have you stopped doing daily activities or avoided exercise because you're afraid of falling?
☐ Yes ☐ No 4) Do you feel unsteady on your feet or shuffle when you walk?
☐ Yes ☐ No 5) Has your hand strength decreased?
☐ Yes ☐ No 6) Has your eyesight diminished, or do you have trouble seeing depth or seeing at night?
☐ Yes ☐ No 7) Do you feel dizzy when you stand up?
☐ Yes ☐ No 8) Have you experienced hearing or vision loss?
☐ Yes ☐ No 9) Do you have foot ulcers, bunions, hammertoes or callouses that hurt or cause you to adjust your steps?
☐ Yes ☐ No 10) Do you experience incontinence? Bowel or Bladder? (circle one or both)
☐ Yes ☐ No 11) Do you currently use a cane or walker, or have you ever been told you should?

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Patient Name: DOB: Date:

PAST MEDICAL HISTORY

Confidential health history questionnaire

(Place a ✓ checK next to the conditions you have now or have had in the past)

☐ Abnormal PAP	☐ Diverticulosis	☐ Mononucleosis	Vaginal infection
☐ AIDS/HIV	☐ Drug dependency	☐ Multiple sclerosis	Venereal disease
☐ Alcoholism	☐ Emphysema	☐ Mumps	Other illness:
☐ Anemia	☐ Fibromyalgia	☐ Pacemaker	
☐ Anorexia/Bulimia	☐ Gallbladder disease	☐ Pneumonia	
☐ Appendicitis	☐ Glaucoma	☐ Polio	
☐ Arthritis	☐ Gout	☐ Prostate problems	
☐ Asthma	☐ Hay fever/ Allergies	☐ Psoriasis	
☐ Bleeding Disorder	☐ Head injury	☐ Psychiatric care	
☐ Blood transfusion	☐ Heart disease	☐ Rheumatic fever	Women only:
☐ Breast lump	☐ Hepatitis	☐ Scarlet Fever	Age started menses:
☐ Cancer	☐ Hernia	☐ Seizures	#Days bleeding:
☐ Cataracts	☐ High blood pressure	☐ Stroke	#Days in cycle:
☐ Chicken pox	☐ High cholesterol	☐ Suicide attempt	#Live births:
☐ Colitis	☐ Hormone therapy	☐ Tonsillitis	#Miscarriages:
☐ Congenital Disorder	☐ Kidney disease	☐ Tuberculosis	#Abortions:
☐ Depression	☐ Measles	☐ Typhoid fever	Contraceptive method:
☐ Diabetes	☐ Migraine	☐ Ulcer (s)	

(please list all the times you have been hospitalized, or operated on)

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

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 fidgety 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 in some way	0 ☐	1 ☐	2 ☐	3 ☐

_____ + _____ + _____

=Total Score: _____

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**
☐	☐	☐	☐

A2663B 10-04-2005

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Patient Name: _____ DOB : _____ Date: _____

PHQ-9 SCORING TABLE		
0-4	None	[G8510]
5-9	Mild Depression	[G8511]
10-14	Moderate depression	[G8431]
15-19	Moderately severe depress	
20-27	Severe depression	[G8431]

Score of PHQ-9: _____ PHQ-9 Depression Screen required on ALL patients annually

☐ Patient Refused Depression Screen on (date): _____

☐ Patient Unable to Complete Depression Screen (please explain):

[G8433- dep scrn not docu] *[Z53.29-pt refusal of proc]*

PREVENTIVE SERVICES AND QUALITY MEASURES

Results/Documentation of all Preventive Services should be present in patient's medical record

Colon Cancer Screening Status (choose 1 or more)

Requirements differ per test; age 50-75

☐ Colon Cancer screen received on (date):

Type of Test: ☐ Colonoscopy (10 yrs) ☐ Fit DNA (Cologuard) (3 yrs)
☐ Sigmoidoscopy (5 yrs) ☐ FOBT/Stool Guiac (1 yr)
☐ Other: _____

Results: ☐ Normal/Negative ☐ Abnormal/Positive

☐ Patient Refused Colon Cancer screen on (date): _____

'proc refits or notation of "normal/abnormal required

Breast Cancer Screening Status (choose 1 or more)

Required every 2 years age 50-74

Mammogram received on (date): _____ Results: ☐ Normal ☐ Abnormal

Other Breast Cancer screen received on (date):. _____

Type of screen: _____ Results: ☐ Normal ☐ Abnormal

Patient Refused Breast Cancer screen on (date): _____

[3014F-mammo results documented and reviewed] *'proc refits or notation of "normal/abnormal required*

REQUIRED MEDICAL RECORD UPDATES:

☐ Past Medical History Reviewed and Updated in patient record today Date: _____

☐ Family History Reviewed and Updated in patient record today Date: _____

☐ Current Medications (including suppliments and OTC meds) and Allergies Reviewed and Updated in patient record today Date: _____

☐ Full Medication List present in chart today Date: _____

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Patient Name:_____ DOB :_____ Date:_____

LIPID PANEL

[3011F-Lipid panel results documented and reviewed]

☐ Date of Last Lipid Panel: _____

☐ Total Cholesterol: _____ HDL:_____ LDL:_____

[3046F-LDL <100]
[3049F-LDL 100-129]
[3050F-LDL >= 130]

[4013F-statin therapy prescribed (even if not taken)]

OTHER PERTINENT PREVENTIVE SERVICES OR LAB RESULTS

ex: Diabetic Foot Exam, PSA results, pelvic exam date and results, etc.

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(This section needs to be filled by patient)

Patient Name:_____ DOB :_____ Date:_____

IMMUNIZATION STATUS (CHECK ALL THAT APPLY)

check here il GRITS report added/updated in chart today

Flu Vaccine

[1030F- flu vaccine status assessed] *["G0008-flu vaccine administered today]*

☐ Vaccine received on (date):_____ *[4274F-vaccine done today OR previously received in current flu season]*

☐ Patient Refused Flu Shot on (date): _____

[4037F-u vaccine ordered but not given today] *[228.21-vaccine refusal]*

Pneumonia Vaccine

[1022F-pneumo vaccine status assessed] *["G0009-pneumo vaccine administered today]*

☐ 1st Pneumonia Vaccine received on (date):_____ *(4040F-vaccine done today OR previously received]*

Type:_____

☐ 2nd Pneumonia Vaccine received on (date):_____ *One Vaccine required after age 65. If vaccine received before 65, then 2nd vaccine required after 66*

Type:_____

☐ Patient Refused Vaccine on (date):_____ *(Update annually)* *[Z28.21-vaccine refusal]*

Shingles Vaccine

☐ Vaccine received on (date): _____

☐ Patient Refused Vaccine on (date):_____ *(Update annually)* *[Z28.21-vaccine refusal]*

Tetanus Shot

☐ Vaccine received on (date): _____

☐ Patient Refused Vaccine on (date): _____ *(Update annually)* *[Z28.21-vaccine refusal]*

Other Vaccines (optional)

☐ Vaccine Name:_____ ☐ Vaccine Name: _____

☐ Received on (date): _____ ☐ Received on (date): _____

☐ Additional Refused Vaccines (name and date refused): _____

USE OF TOBACCO, ALCOHOL AND RECREATIONAL DRUGS *(CHECK)*:

☐ Tobacco Current Status: ◯ Current ◯ Quit (date) _____ ◯ Never

☐ Alcohol Current Status: ◯ Current ◯ Quit (date) _____ ◯ Never

☐ Recreational Drugs Current Status: ◯ Current ◯ Quit (date) _____ ◯ Never

DIABETIC PATIENTS ONLY

☐ Haemoglobin A1C (required annually) Date: _____ Value: _____

☐ Diabetic Retinopathy Dilated Eye Exam Date: _____ ☐ Negative ☐ Positive

(2022F-Dilated retinal eye exam w/ intercept donum & reviewed) *(3072F-low risk for retinopathy (neg test)]*

Sumana Ketha M.D.
Board certified in Internal Medicine

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DFW Primary Care PLLC

(This section needs to be filled by physician / provider)

Patient Name: _____ DOB : _____ Date: _____

Personalized Prevention Plan

Based on the results of your Annual Wellness Visit today, the following Preventive Services and/or Counselling Topics have been recommended for you by your Healthcare Provider.

Personalized Prevention Plan for _____ Date _____

Preventive Health	Counselling
☐ Mammogram (every 2 yrs. age 50-74)	☐ Nutrition / Healthy Eating
☐ Bone Density scan (routinely as needed)	☐ Weight Loss
☐ Colonoscopy (every 10 yrs after age 50)	☐ Diabetic Meal Planning
☐ Cologuard/FIT DNA (every 3 yrs after age 50)	☐ Other Special Diet:
☐ Flu shot (annually August - March)	☐ Physical Activity / Exercise
☐ Pneumonia shot (1-2 doses up to age 64, 1 dose age 65+)	☐ Depression / Mental Health
☐ Shingles vaccine (once/lifetime)	☐ Smoking Cessation
☐ Other vaccination:	☐ Drug / Alcohol Abuse
☐ Blood work:	☐ Pain Management
☐ Cholesterol (routinely)	☐ Sexual Health
☐ Haemoglobin A1C (every 6 mo. for diabetics)	☐ Fall Prevention / Safety at Home
☐ CBC (complete blood count) (routinely)	☐ Advance Directive
☐ PSA (annually after age 50)	☐ Other:
☐ Pelvic Exam/Pap (every 3-5 yrs. to age 65)	
☐ Vision check (every 1-2 yrs)	**Outreach**
☐ Other:	☐ Discussed in Home Physician Visits
	☐ Referred to Outreach Program

Additional notes or recommendations

If you have any other questions about your health, please be sure to speak with your Healthcare Provider.

Your next Annual Wellness Visit is schduled for: _____

Medical Professional to complete the Personalized Prevention Plan then check and sign below:

☐ **Areas of concern within the Annual Wellness Visit have been addressed, counseling has been offered, and a Personalized Prevention Plan has been covered with patient.**

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(This section needs to be filled by physician / provider)

Patient Name: _____ DOB : _____ Date: _____

CARE OF OLDER ADULT ASSESSMENT FORM

Height: _____ Weight: _____ Blood Pressure: _____ BMI: _____

Advance Care Planning (CPT II: 1123F, 1124F.1157F.1158F)	**Functional Status Assessment** (CPT 11: 1170FL)
Date discussed with Patient/Caregiver: **Copy of Advance Care Plan in patient's chart:** ☐ **Yes** ☐ **No** Patient has: ☐ Advance Directives ☐ Surrogate Decision Maker ☐ Living Will ☐ Actionable Medical Orders	Date Assessed: **Were patient's ADLs/ iADLs assessed?** ☐ **Yes** ☐ **No** <u>Check the most appropriate for ALL the below:</u> Cognitive Status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Ambulation Status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Hearing: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Vision: ☐ Excellent ☐ Good ☐ Fair ☐ Poor Speech: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Pain Assessment (CPT II: 112sF, 1126F)

Date Assessed: . Does the patient have pain? ☐ Yes ☐ No

Medication List and Review (SPT II: 1159F.1160F)

Attach the member's medication list OR document all prescriptions. over the counter and herbal supplements below.

Date Medication List Attached: ☐ Patient not taking any medications: ☐

Medication/Dosage/Frequency	Medication/Dosage/Frequency

Provider Name (Print): _____

Credentials: ☐ MD ☐ DO ☐ NP ☐ PA ☐ PharmD ☐ Other: _____

If the form is filled out by an office or clinical support staff member. it must route back to the provider for follow-up and sign off.

Submit Print

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(This section needs to be filled by physician / provider)

Patient Name:_____ DOB :_____ Date:_____

VITAL SIGNS

Height	Weight	BP	HR	RR	Temp

PHYSICIAN / PROVIDER NOTES