Norfolk Medical Group

To: Our Medicare Patients

Subject: Your Medicare Annual Wellness Visit

Medicare covers a Medicare Annual Wellness Visit every year. You may receive an Annual Wellness visit after you have been with Medicare for more than one year, or it has been at least one year since your "Welcome to Medicare" visit. These are covered yearly as long as it has been at least 366 days since your previous Medicare Annual Wellness Visit.

An Annual Wellness Visit is not the same thing as what many people often refer to as their yearly physical exam. Medicare is very specific about what the Annual Wellness Visit includes and excludes.

At the Annual Wellness Visit your doctor will review your health risk assessment, your current medical providers and medical history, screen you for depression and memory loss, and determine your functional ability and level of safety. You will be provided with a personalized prevention plan to keep you healthy. The visit does not include a comprehensive physical exam, discussion or testing regarding any new or current medical problems, conditions or medications. You may schedule another visit to address those issues or your doctor may charge the usual Medicare fess for such services that are beyond the scope of the Medicare Annual Wellness visit.

We encourage you to be familiar with your insurance policy and coverage. Please refer to the following codes when discussing coverage with your insurance provider

First Annual Wellness visit = G0438

Subsequent Annual Wellness visit = G0439

Please bring the following to your appointment:

- ✓ Your insurance card(s)
- ✓ Completed questionnaire enclosed with this letter
- ✓ Your prescription medication and over-the counter medication bottles including vitamins and supplements
- ✓ Immunization records
- ✓ Copies of Advance Directives – forms can be found on the Norfolk Medical Group website:

Norfolkmedicalgroup.com

We look forward to seeing you. Thank you for choosing Norfolk Medical Group for your health care needs.

MEDICARE ANNUAL WELLNESS VISIT QUESTIONNAIRE
Date: Date of Birth:

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Last Name: **First Name:** **MI:**

In an effort to ensure optimal care coordination, please list all providers you see on a regular basis

PROVIDERS INVOLVED IN YOUR HEALTHCARE	**Specialty**

HEARING SCREEN

Do you find it difficult to follow a conversation in a noisy restaurant or crowded room? ☐ Yes ☐ No
Do you sometimes feel that people are mumbling or not speaking clearly? ☐ Yes ☐ No
Do you experience difficulty following dialogue in the theater or while watching TV? ☐ Yes ☐ No
Do you find yourself asking people to speak up or repeat themselves? ☐ Yes ☐ No
Do you sometimes have difficulty understanding speech on the telephone? ☐ Yes ☐ No
Do you experience ringing or noises in your ears? ☐ Yes ☐ No
Do you hear better with one ear than the other? ☐ Yes ☐ No

FUNCTION SCREEN

Do you need helping feeding yourself? ☐ Yes ☐ No
Do you need help getting from bed to chair? ☐ Yes ☐ No
Do you need help getting to the toilet? ☐ Yes ☐ No
Do you need help getting dressed? ☐ Yes ☐ No
Do you need help bathing or showering? ☐ Yes ☐ No
Do you need help walking across the room (includes using cane or walker)? ☐ Yes ☐ No
Do you need help using the telephone? ☐ Yes ☐ No
Do you need help taking your medicines? ☐ Yes ☐ No
Do you need help preparing meals? ☐ Yes ☐ No
Do you need help managing money (like keeping track of expenses or paying bills)? ☐ Yes ☐ No
Do you need help shopping? ☐ Yes ☐ No
Do you need help with transportation? ☐ Yes ☐ No
Do you need help climbing a flight of stairs? ☐ Yes ☐ No

HOME SAFETY SCREEN

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Do you have easy access to a phone at home? ☐ Yes ☐ No
Are emergency numbers easily accessible? ☐ Yes ☐ No
Do you have functioning smoke/carbon monoxide alarms in your home? ☐ Yes ☐ No
Do you have non-slip surface and grab bars in bath/shower? ☐ Yes ☐ No
If you climb stairs at home, are there secure railing? ☐ Yes ☐ No

NUTRITION
Number of servings of fruits do you have a day?
☐ 1-3 ☐ 4-7 ☐ 7-10 ☐ >10 ☐ NONE
Number of servings of vegetables do you have a day?
☐ 1-3 ☐ 4-7 ☐ 7-10 ☐ >10 ☐ NONE

ADVANCED CARE PLANNING
Do you wish to discuss end-of-life issues with the provider? ☐ Yes ☐ No

DEPRESSION SCREENING
PHQ-9
0-Not at all 1-Several days 2- More than half the days 3-Nearly everyday
Little interest or pleasure in doing things _____
Feeling down, depressed, or hopeless _____
Trouble falling or staying asleep, or sleeping too much _____
Feeling tired or having little energy _____
Poor appetite or overeating _____
Feeling bad about yourself-or that you are a failure or have let yourself or your family down _____
Trouble concentrating on things, such as reading the newspaper or watching television _____
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 _____
Thoughts that you would be better off dead, or of hurting yourself in some way? _____

ALCOHOL SCREENING
Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No
If yes, how often did you have a drink containing alcohol in the past year?
☐ monthly or less ☐ 2 to 4 times a month ☐ 2 to 3 times per week ☐ 4 or more times a week
If yes, how many drinks did you have on a typical day when you were drinking in the past year?
☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more
If yes, how often did you have six or more drinks on one occasion in the past year?
☐ never ☐ less than monthly ☐ monthly ☐ weekly ☐ daily or almost daily

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EXERCISE

How many days a week do you exercise?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Duration:

☐ 30 minutes each time ☐ Less than 30 minutes each time ☐ more than 30 minutes each time

TOBACCO SCREENING

Are you a?

☐ Non-smoker ☐ Former smoker ☐ Current daily smoker ☐ Current some day smoker

☐ Chewing tobacco

user

If **former smoker**, how long has it been since you last smoked?

☐ < 1 month ☐ 1-3 months ☐ 3-6 months ☐ 6-12 months ☐ 1-5 years ☐ 5-10 year ☐ >10 years

If **current daily smoker**, how many cigarettes a day do you smoke?

☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more

If **current daily smoker**, how soon after you wake up do you smoke?

☐ within 5 min ☐ 6-30 min ☐ 31-60 min ☐ after 60 min

If **current daily smoker**, are you interested in quitting?

☐ Ready to quit ☐ Thinking about quitting ☐ Not ready to quit

FALL RISK ASSESSMENT

Have you fallen in the past year? ☐ Yes ☐ No

If yes, how many times? ☐ 1 ☐ >2

Were you injured? ☐ Yes ☐ No

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MEDICARE ANNUAL WELLNESS VISIT PHYSICIAN WORKSHEET

Mini-Cog test

1. Word recollection (Banana, Sunrise, Chair)

Have patient repeat the 3 words, tell them to remember them.

2. Clock drawing

Give the following instructions.

1. Draw a clock in the space below.

2. Set the hands to show 11:10.

3. Word recollection

Ask patient to repeat the words in step 1.

Scoring:

_____1 point each word patient recalls

_____2 point for normal clock; 0 points for abnormal clock

_____Total Score

0 – 3 = possible impairment

3 – 5 = suggests no impairment

_____ _____

Provider Signature Date