MiCMRC Return Visit Note V5

Patient Name:

DOB:

MRN:

Patient phone:

Alternative contact/phone:

Name of person spoke with if other than patient and relationship:

Date of visit:

Primary Care Physician (PCP) contact information:

Care Manager Name and Licensure:

Type of visit: ◯ Phone ◯ Face-to-face

Visit duration in minutes: ◯ 5-10 ◯ 11-20 ◯ 21-30 ◯ 31-60 ◯ >60

Consent for care management: ◯ Yes ◯ Verbal consent ◯ Declined

Current Diagnoses:

Surgeries/Surgeon:

Allergies:

Comments:

Subjective

Patient/Caregiver self-reported problems/concerns:

Medication Reconciliation

Pharmacy Name, Location, Phone:

Barriers to Adherence:

- ☐ No barriers identified
- ☐ Financial issues
- ☐ Too many medications
- ☐ Patient forgets
- ☐ Ineffective per patient
- ☐ Does not understand purpose of medication
- ☐ Unable to open medication bottles
- ☐ Other:

Side Effects:

- ☐ No reported side effects
- ☐ Side effects reported, specified below
- ☐ Potential Interactions

Comments:

Adherence Aids:

- ☐ Pill box
- ☐ Calendar/schedule supplied by nurse
- ☐ Other:

If pill box used, it is filled by:

Medications Reconciled:

- ☐ Yes
- ☐ No new medications
- ☐ Medication changes, specified below

Comments:

Reviewed with whom:

Medication Reconciliation Comments:

REVIEW OF SYSTEMS

Patient/Other reports:

Vision: ☐ No problem ☐ 20/20 corrected ☐ Uses readers

Cataracts: ☐ R ☐ L

Macular degeneration ☐ R ☐ L

Blind ☐ R ☐ L

Other:

Comments:

Hearing: ☐ No problem ☐ Hard of hearing ☐ Reads lips ☐ Uses sign language

Wears hearing aids ☐ R ☐ L

Deaf ☐ R ☐ L

Other:

Comments:

Oral/Dental: ☐ Good dentition ☐ Gingivitis ☐ Canker sores ☐ Tongue lesions ☐ Difficulty swallowing ☐ Dentures/Partials ☐ Mucositis

Missing teeth: ☐ Upper R ☐ Upper L ☐ Lower R ☐ Lower L

Other:

Comments:

Cardiovascular: ☐ No problem ☐ Edema ☐ Fatigue ☐ Pallor ☐ Hx DVT ☐ Chest pain / angina

Characterize chest pain / angina:

Other:

Comments:

Pulmonary: ☐ No problem ☐ Wheezing ☐ Cough ☐ Short of breath ☐ Hx pleurodesis

O2 in use: ☐ Yes ☐ No

If O2 in use, liters per minute:

Other:

Comments:

Sleep Hygiene: ☐ No problem ☐ Sleep apnea ☐ Uses CPAP ☐ Excessive snoring

Other:

Comments:

Chills: ◯ Yes ◯ No

Sweats: ◯ Yes ◯ No

Fever: ◯ Yes ◯ No

Comments:

Thermometer to take temperature at home ◯ Yes ◯ No

Neurological: ☐ No problem ☐ Numbness / tingling ☐ Foot drop

Other:

Comments:

Musculoskeletal: ☐ No problem ☐ Arthralgia ☐ Myalgia ☐ Weakness ☐ Abnormal coordination

Other:

Comments:

GI: ☐ No problem ☐ Stomatitis ☐ Colostomy ☐ Ileostomy ☐ Dumping syndrome ☐ Hx Paracentesis ☐ Irritable bowel ☐ Constipation ☐ Hemorrhoids ☐ GERD ☐ Hx ulcers ☐ Hiatal hernia ☐ Whipple procedure ☐ Nausea ☐ Vomiting ☐ Diarrhea

If diarrhea or vomiting, number of episodes in 24 hours:

Other:

Comments:

GU:

- ☐ No problem
- ☐ Chronic UTI
- ☐ Frequency
- ☐ Burning
- ☐ Incontinence
- ☐ Hx urethral stent
- ☐ Ureterostomy
- ☐ ileal pouch
- ☐ Impotent/ED
- ☐ Penile implant

Other:

Comments:

Gynecological:

- ☐ No problem
- ☐ Pre-menopausal
- ☐ Post-menopausal
- ☐ Vaginal stenosis
- ☐ Hx TAH & BSO
- ☐ Cystitis
- ☐ Hx STD
- ☐ Pregnant

If pregnant, gestational age:

Last pelvic exam/pap smear date:

Other:

Comments:

Skin:

- ☐ No problem
- ☐ Stump
- ☐ Stoma
- ☐ Dermatitis
- ☐ Bruising
- ☐ Jaundice
- ☐ Wounds

Location/description if any wounds:

Other:

Comments:

Any additional Review of Systems Comments:

PAIN

- ☐ Denies pain
- ☐ Chronic
- ☐ Acute

Frequency:

Intensity/Pain Scale (1-10)

Character:

Duration:

Treatment of pain: ☐ Pharmaceutical ☐ Non-Pharmaceutical

Comments:

NUTRITIONAL STATUS

☐ Stable
☐ Recent weight loss greater than 5% in one month
☐ Decreased appetite/intake decline last 3 months

Nutrition-related preferences: ☐ Supplements ☐ Vegan ☐ Vegetarian
☐ Kosher

Other:

Recommended diet:

Tube feedings: ☐ No problem ☐ Problems ☐ NA

Average daily liquid intake:

Number of feedings/meals per day:

Comments:

Smoking Status

☐ Non-smoker
☐ Second-hand exposure
☐ Interested in smoking cessation
☐ Smoker
☐ e-cigarettes
☐ chewing tobacco

If patient smokes, how many packs per day for how many years?

Exercise
Does patient exercise regularly? ☐ Yes ☐ No

Comments:

Depression Screening

Over the last 2 weeks, how often has the patient been bothered by any of the following problems?

	Not at all Score 0	Several days Score 1	More than half the days Score 2	Nearly every day Score 3
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	○	○	○	○

Patient Total Score: _____

Are there signs / symptoms present for caregiver distress/ anxiety problems?

- ☐ Yes
- ☐ No
- ☐ Referred to care team social worker
- ☐ Reviewed with social worker

Other: _____

Comments:

ADVANCE CARE PLANNING

Does the patient have any of the following?

Advance Directive (living will, durable power of attorney for health care, health care proxy ◯ Yes ◯ No

Do not resuscitate order ◯ Yes ◯ No

Do not resuscitate order in community ◯ Yes ◯ No

Court appointed guardian ◯ Yes ◯ No

Durable power of attorney for financial ◯ Yes ◯ No

If the patient DOES NOT have an advance directive, does the patient or a support person want information?
☐ No, not interested
☐ No, already has information
☐ Yes

Comments:

If answered yes to the above, are the document(s) in the patient's medical record?
◯ Yes
◯ No

If yes, describe:

PLAN OF CARE

Palliative Care: ◯ Yes ◯ No

Comments:

CARE MANAGEMENT ASSESSMENT

Fall Risk: ◯ Yes ◯ No

History of falls in the past 12 months: ◯ Yes ◯ No

If yes, describe fall risk:

- ☐ Polypharmacy
- ☐ Pain or sedating medications
- ☐ Gait disturbance
- ☐ Muscle weakness
- ☐ Assistive devices (if yes, describe in comments)
- ☐ Other:

Comments:

DME Needed: ☐ Yes ☐ No

Comments:

Barriers Identified:

Interventions to Address Barriers:

SELF-MANAGEMENT ACTION PLAN

Asthma ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

CAD ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

COPD ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Diabetes ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

CHF ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

HTN ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Medication Therapy ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Osteoporosis ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Depression ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

CKD ☐ Yes ☐ NA

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Other, please specify:

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Preventive Care - Follow Up

Short Term Goal and Target Date:

Long Term Goal and Target Date:

Coordination of Services:

Summary:

Re-evaluation of Plan of Care and Progress Toward Goals Achievement:

Follow-up planned and time frame:

Level of understanding:

Readiness for change:

Care Manager Signature and Date:

If this box is checked, please see Care Manager addendum to Return Visit note: ☐