MiCMRC Adult Comprehensive Assessment V7

Patient Name:

DOB:

MRN:

Patient phone:

Other individuals in attendance/ relationship:

Date of visit:

Primary Care Physician (PCP) contact information:

Care Manager Name and Licensure:

Physician Specialists:

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

Active Diagnoses:

Surgeries/Surgeon:

Hospitalization/ED Summary: ☐ Multiple hospitalizations in the past year ☐ Multiple ED admissions in the past year

Other/Comments:

Patient self-reported problems and concerns:

Allergies:

Additional Care Team(s)

Currently using Home Health Agency (HHA):

- ◯ Yes
- ◯ Not used at this time

HHA Agency Name, Contact, Phone Number:

Frequency:

If Previous HHA Used: Agency Name, Contact, Phone Number:

Home Health Agencies:

- ☐ Not indicated at this time
- ☐ Nursing
- ☐ Social Worker
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Meals on Wheels
- ☐ Other:

Indicate if any of the above therapies were used in the past:

Currently using DME agency:

- ◯ Yes
- ◯ Not used at this time

DME Equipment used , Agency Name, Contact, Phone Number:

Other Outpatient Therapies:

- ☐ Not indicated at this time
- ☐ Behavioral health
- ☐ Radiation therapy
- ☐ Cardiac evaluation
- ☐ Pulmonary Assessment
- ☐ Anticoagulation
- ☐ Diabetes management/education
- ☐ Infusion services
- ☐ Dialysis
- ☐ Transfusion services
- ☐ Central line/port placement
- ☐ Rehabilitation
- ☐ Cryopreservation
- ☐ Genetic counseling
- ☐ Other:

Outpatient Therapy Agency Name, Contact, Phone number:

Comments:

Medication Reconciliation

Pharmacy Name, Location, Phone:

Barriers to Adherence:

- ☐ No identified barriers
- ☐ Financial issues
- ☐ Unable to obtain medications
- ☐ No refills
- ☐ Complexity of medications
- ☐ Does not understand purpose of medication
- ☐ Side effects
- ☐ Ineffective per patient
- ☐ Too many medications
- ☐ Unable to open 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:

Subjective

Patient/Caregiver Concerns:

Income:	☐ Patient	☐ Caregiver
Food	☐ Patient	☐ Caregiver
Medication	☐ Patient	☐ Caregiver
Utilities	☐ Patient	☐ Caregiver
Housing	☐ Patient	☐ Caregiver
Legal	☐ Patient	☐ Caregiver
Immigration	☐ Patient	☐ Caregiver
Other, please specify below	☐ Patient	☐ Caregiver

Comments:

Other may include: Healthcare, Childcare, Education, or Clothing & Household supplies.

How does the patient rate their health status: ◯ Good ◯ Fair ◯ Poor

Social History

Occupation:

Marital status:
☐ Married ☐ Single
☐ Divorced ☐ Separated
☐ Widowed ☐ Significant Other

Does patient live alone?
◯ Yes
◯ No

If no, who does patient live with:

Mobility Status, Activities of Daily Living and Physical Rehabilitation

Patient/Other reports:

Has the patient been referred for physical rehabilitation? ◯ Yes ◯ No

Level of assistance with Activities of Daily Living:
☐ Independent
☐ Requires total care

Assistance required with:
☐ Bathing ☐ Toileting
☐ Dressing ☐ Medications
☐ Meals ☐ Housekeeping
☐ Laundry ☐ Transportation
☐ Shopping ☐ Finances
☐ Appointments
☐ Other:

General hygiene: ◯ No problem ◯ Poor

Regular exercise: ◯ Yes ◯ No

Physical limitations: ◯ Yes ◯ No

Describe Functional Status:

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 thoracentesis ☐ Hx pleurodesis

Pleural effusion/dullness: ☐ R ☐ L

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

Has thermometer to take temperature at home: ◯ Yes ◯ No

Comments:

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:

Does the patient have access to affordable and healthy food?

◯ Yes
◯ No

Comments:

COMMUNICATION STATUS

Preferred language for health care:

Preferred language for printed materials:

Interpreter needed: ☐ Yes ☐ No

Other identified barriers to communication:

Health literacy assessment:

Comments:

HOUSING, SOCIAL SUPPORT AND SPIRITUALITY

Are there stairs in the home?
- ◯ Yes
- ◯ No

Is the home dwelling safe?
- ◯ Yes
- ◯ No

If not safe, indicate concerns:
- ☐ Heat
- ☐ Water
- ☐ Electrical
- ☐ Other:

Comments on housing:

What is the patient's mode of transportation? (Check all that apply.)
- ☐ Walk
- ☐ Drives self
- ☐ Public bus
- ☐ Family
- ☐ Friends
- ☐ Taxi (self-pay)
- ☐ ADA transport
- ☐ Insurance funded transport
- ☐ Other:

Does the patient have reliable transportation to/from the doctor's office? ◯ Yes ◯ No

Comments on transportation:

What is the level of involvement of family and friends on a regular basis with the patient, including phone calls, emails, etc.?

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Less frequently than monthly

Does the patient have the support of a caregiver?

☐ Yes ☐ No

If yes, name of caregiver:

Describe level of support caregiver provides:

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

- ☐ No caregiver is involved
- ☐ Yes
- ☐ No
- ☐ Referred to care team social worker
- ☐ Reviewed with social worker
- ☐ Other:

Comments on caregiver:

How does the patient cope with life events and daily stress? (Check all that apply.)

- ☐ Keeps it to him/herself
- ☐ Talks to family
- ☐ Talks to friends
- ☐ Prays
- ☐ Talks to a professional
- ☐ Support group
- ☐ Internet resources

Is the patient involved in community activities, groups, social events, or volunteering?

◯ Yes ◯ No

If yes, describe:

What has the patient previously done for enjoyment or recreation?

Is (s)he able to engage in these activities now?

◯ Yes ◯ No

Does the patient report having adequate support?

◯ Yes ◯ No

If no, what support is desired?

What is the patient's spiritual or religious affiliation:

Are there any specific cultural or spiritual practices/ restrictions the health care team should know about when providing care? ◯ Yes ◯ No

If yes, describe:

Comments on social support/ spirituality:

SEXUALITY

Is the patient sexually active? ◯ Yes ◯ No

Is the patient using birth control? ◯ Yes ◯ No

If yes, indicate method used:

ABUSE/DOMESTIC VIOLENCE

Referred to care team social worker: ◯ Yes ◯ No

Has someone in your household ever:

- ☐ Used or threatened to use weapons against you?
- ☐ Choked, or attempted to strangle you?
- ☐ Taken you or your children hostage to get what he or she wants?
- ☐ Stalked you?
- ☐ Hurt or threatened to hurt your children?

If yes, has the abuse been getting worse? ◯ Yes ◯ No

Are you afraid for your life? ◯ Yes ◯ No

Does your partner use alcohol or drugs? ◯ Yes ◯ No

Comments:

COGNITIVE

Patient/caregiver reports problems: ◯ Yes ◯ No

Identified potential for:

- ☐ Short term memory loss
- ☐ Long term memory loss
- ☐ Understands some instructions
- ☐ Processes some information
- ☐ Difficulties with communication

Comments:

MENTAL HEALTH STATUS

Has the patient participated in counseling?

- ☐ Yes, in the past
- ☐ Currently in counseling
- ☐ No

If yes, or currently in counseling how does patient describe their experience?

Does the patient report any history of substance use to help them calm down, feel better, reduce stress, or just have fun?

- ◯ Yes
- ◯ No

If yes, complete:

- ☐ Alcohol
- ☐ Cocaine
- ☐ Crystal meth
- ☐ Marijuana
- ☐ Other:

Has the patient ever received drug or alcohol treatment?

- ◯ Yes
- ◯ No

If yes, describe:

How often does the patient have a drink containing alcohol?

- ☐ Never
- ☐ Monthly or less
- ☐ 2 to 4 times a month
- ☐ 2 to 3 times a week
- ☐ 4 or more times a week

Has a relative, friend, doctor, or another health worker been concerned about the patient's drinking and suggested that they cut down?

- ☐ No, never drinks
- ☐ Yes, but not in the last year
- ☐ Yes, within the last year

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?

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: ☐

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:

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:

Preventive Care ☐ 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:

Date of most recent health screening:

Date of Colonoscopy:

Date of PAP:

Date of Prostate Exam:

Date of Mammogram:

Date of A1C:

Date of Vision Screening:

Date of Influenza vaccine:

Date of pneumococcal vaccine:

Date of Shingles vaccine (Zostavax):

Coordination of Services:

Referred to: ☐ DME ☐ HHA ☐ PCP ☐ ED

Advance Care Planning:

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:

Physician Signature and Date:

If this box is checked, please see Care Manager addendum to Comprehensive Assessment. ☐