



North Charlotte Medical Specialists

Jennifer Burke, MD
Richard Mitlehner, MD
Matthew Moll, MD
Laura Lupton, MD
Nancy Durning, FNP-C
Tina Bostic, Manager

I would like to welcome you to North Charlotte Medical Specialists-University for your "Welcome to Medicare" physical (also known as IPPE.)

We have your appointment scheduled for

_____ with Dr. _____

We need you to complete 2 enclosed forms **PRIOR** to arriving to the office for your appointment:

1. Patient History Form
2. Functional Abilities/Depression Questionnaire.

Please bring these 2 **completed** forms to your visit along with your Medicare card.

We have also enclosed an information sheet called "Medicare Preventive Services." This explains each individual preventive service, who is covered for these services, and the frequency allowed, now that you are covered by Medicare insurance.

Thank you for choosing North Charlotte Medical Specialists-University as your Primary Care Provider and Medical Home.

Sincerely,

Tina Bostic
Practice Manager

WELCOME TO MEDICARE VISIT

This is a one-time benefit during the 1st year of Medicare coverage. It is a review and consultation visit only, and *does not include a routine full physical exam.*

Prior to arrival for the visit, information forms required by Medicare must be completed and include a patient history form, depression screen and functional abilities questionnaire.

The visit consists of review of your pre-completed information forms, vital signs measurement, visual acuity testing and a written checklist for education, counseling and referral for tests and services covered under the Medicare preventive benefits.

At the end of the visit, a written summary will be given and any needed tests can be scheduled.

A routine full physical examination is *not* a covered benefit under Medicare but can be scheduled for a different time.

Evaluation of any problem or followup for any chronic illnesses will need to be scheduled for a different visit. This will ensure sufficient time to discuss services available to promote your health.

Patients requesting this visit may call to schedule and will be mailed the forms for completion prior to the visit.

ANNUAL WELLNESS VISIT

Beginning in 2011, Medicare will cover an annual wellness visit. This can only be done after the 1st year of Medicare eligibility, and must not be done within 12 months of having received the initial "Welcome to Medicare Visit".

Similar to the initial "Welcome" visit, it includes a health risk assessment and a personalized prevention plan with development of a yearly schedule for appropriate preventive services. The visit *does not include a routine full physical exam.*

Required elements are a review of medical and family history, prescribed medication review, listing of all physician providers, measurement of vital signs, observation for detection of cognitive impairment, screening for depression and a functional ability assessment.

Also included is a delineation of risk factors with plans for intervention and referral for health education or preventive services.

This is *not* meant to take the place of a routine physical exam, and followup for management of chronic problems will be done at a separate visit. This will ensure sufficient time to discuss services available to promote your health.

MEDICARE PREVENTIVE SERVICES

WELCOME TO MEDICARE VISIT & ANNUAL WELLNESS VISIT



Carolinus HealthCare System

Uncompromising Excellence. Commitment to Care.

MEDICARE PREVENTIVE SERVICES*

PREVENTIVE SERVICE	WHO IS COVERED	FREQUENCY	BENEFICIARY PAYS
Welcome to Medicare Visit	1 st Medicare year	Once	No copayment / no deductible
Annual Wellness Visit – 1 st	After 1 st Medicare year and not within 12 months of Welcome Visit	Once	No copayment / no deductible
Annual Wellness Visit -subsequent	More than 12 months after 1 st Annual Wellness Visit	Annually	No copayment / no deductible
Cardiovascular Screening (lipid test)	All	Every 5 years	No copayment / no deductible
Diabetes Screening (fasting glucose)	Those with risk for diabetes	Annually	No copayment / no deductible
Screening Gynecologic Exam	All females	Every 24 months	No copayment / no deductible
Screening Mammography	All females 40 and older	Annually	No copayment / no deductible
Bone Mass Measurement	All at risk for osteoporosis	Every 24 months	No copayment/ no deductible
Colorectal Cancer Screening (colonoscopy)	Age 50 and older	Every 10 years	No copayment / no deductible
Prostate Cancer Screening (PSA test)	Males 50 and older	Annually	No copayment / no deductible
Ultrasound Screening for Abdominal Aortic Aneurysm	Male current or former smokers age 65-75	Once	No copayment / no deductible
Seasonal Influenza Vaccine	All	Annually	No copayment / no deductible
Pneumococcal Vaccine	All	Once	No copayment / no deductible

* Adapted from “Quick Reference Information: Medicare Preventive Services”, published by Medicare Learning Network (official CMS information for fee for service physicians, Centers for Medicare & Medicaid Services). Please see http://www.cms.gov/MILNProducts/downloads/MPS_QuickReferenceChart_1.pdf for a complete listing.

Patient History Form

DATE ____/____/____

Patient Name _____ Age _____ Date of Birth ____/____/____ MRN # _____

As part of your Medicare **initial preventive physical exam**, please complete the following questionnaire to the best of your ability. It is an important and confidential part of your medical record.

Primary Care Doctor: _____

Do you currently suffer from any of the following conditions? (Please check all that apply.)

<u>Yes</u>	<u>No</u>	<u>Condition</u>	<u>Yes</u>	<u>No</u>	<u>Condition</u>	<u>Yes</u>	<u>No</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Coronary Artery Disease
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema / COPD	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	Cancer

Have you or others in your immediate family (parents, grandparents, brothers, sisters, children or grandchildren) had any of the following? (Please check all that apply.)

<u>Condition</u>	<u>Self</u>	<u>Family Member (list relation)</u>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>

<u>Condition</u>	<u>Self</u>	<u>Family Member (list relation)</u>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Other Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>

Please list any hospitalizations or surgeries you have undergone and the year performed:

<u>Hospitalization / Surgery</u>	<u>Year</u>	<u>Hospitalization / Surgery</u>	<u>Year</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please List All Current Medications and Supplements (include over-the-counter & prescription medicine):

List Any Medication Allergies or Intolerances:

Do you have any other allergies? Yes No; If yes, please specify allergy and reaction _____

Physician Signature _____ Date _____

Date Reviewed: 06/2007; 1/2008; 12/2008, BH; 07/09 VC; 12/2009 BH

Functional Abilities / Depression Questionnaire

Patient Name: _____

Date: _____

Functional Abilities Assessment: Please indicate (✓) if you require assistance with any of the following activities.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Eating | <input type="checkbox"/> Preparing meals | <input type="checkbox"/> Moving in and out of bed or chairs | <input type="checkbox"/> Driving or accessing transportation services |
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Housework | <input type="checkbox"/> Following a prescribed drug regimen | |
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Shopping | | |
| <input type="checkbox"/> Grooming | <input type="checkbox"/> Climbing stairs | | |
| <input type="checkbox"/> Going to the toilet | <input type="checkbox"/> Communicating with others | | |

Please select (✓) the best answer for each of the following questions about home safety.

Yes No

		Do you have any hearing difficulty or require hearing aid(s)?
		Are lamp, extension and telephone cords placed out of the flow of traffic?
		Are cords in good condition, out from under rugs and furniture?
		Do extension cords always carry their proper load?
		Are all small rugs and runners slip resistant?
		Are emergency numbers posted on or near telephones?
		Could you access a telephone should you experience a fall that prevents you from standing?
		Are all smoke detectors properly placed and in good working order?
		Are all small stoves and heaters placed where they cannot be knocked over and away from furnishings (furniture, curtains, rugs, etc.)?
		Is wood burning equipment installed properly?
		Do you have an emergency exit plan and alternate exit plan in case of fire?
		Are towels, curtains, and other things that might catch fire located away from the range?

Yes No

		Are all extension cords and appliance cords located away from the sink or range areas?
		Are hallways, passageways between rooms, and other heavy traffic areas well lit?
		Are exits and passageways kept clear?
		Are bathtubs and showers equipped with non-skid mats, abrasive strips, or surfaces that are not slippery?
		Do bathtubs and showers have at least one (preferably two) grab bars?
		Are all medicines stored in the containers that they came in and are they clearly marked?
		Is a lamp or light switch within reach of your bed?
		Are ash trays, smoking materials or other fire sources (heaters, hot plates, teapots, etc.) located away from beds or bedding?
		Are heating pads always turned off before going to sleep?
		Is there a telephone close to your bed?
		Are stairs well lighted?
		Do the stair steps allow for secure footing?

Depression Assessment: For each of the following questions, please select (✓) the answer that best represents how you have felt over the past week.

Yes No

		Have you dropped many of your activities of interest?
		Do you feel that your life is empty?
		Do you often get bored?
		Are you afraid that something bad is going to happen to you?
		Do you often feel helpless?
		Do you prefer to stay home, rather than going out and doing new things?
		Do you feel you have more problems with memory than most?
		Do you feel pretty worthless the way you are right now?

Yes No

		Do you feel that your situation is hopeless?
		Do you think most people are better off than you are?
		Are you basically satisfied with your life?
		Are you in good spirits most of the time?
		Do you feel happy most of the time?
		Do you think it is wonderful to be alive?
		Do you feel full of energy?

Physician Signature: _____