Medicare Members

MEDICARE ANNUAL WELLNESS VISIT TOOLKIT

www.california.providence.org
1-888-432-5464
What’s Inside:
Medicare Annual Wellness

Height, weight, BMI, blood pressure and other medically necessary routine measurements:
Your doctor may perform some routine, but important measurements, including your height, weight, Body Mass Index, and blood pressure at your MEDICARE ANNUAL WELLNESS VISIT. Some other measurements may be performed at the MEDICARE ANNUAL WELLNESS VISIT.

Detection of any cognitive impairment and review of functional ability and level of safety:
Your doctor will ask you some questions about changes in memory, language and the ability to complete routine tasks. Fill out these forms to help you when you have your appointment.

GENERAL HEALTH
How would you describe your general health?
☐ Good  ☐ Fair  ☐ Poor

How would you rate your health compared to others your age?
☐ Better  ☐ Same  ☐ Worse

HEARING AND VISION
Do you feel that a hearing or vision difficulty limits or hampers your personal life?
☐ Yes  ☐ No

Do you wear hearing aids?
☐ Yes  ☐ No

Do you wear glasses?
☐ Yes  ☐ No

FUNCTIONAL SCREEN
Do you need help with dressing, eating, bathing or going to the bathroom?
☐ Yes  ☐ No

Do you need help with preparing meals, transportation, shopping, managing your finances, or taking your medicine?
☐ Yes  ☐ No

Do you drive?
☐ Yes  ☐ No

Have you ever been told that you should stop driving?
☐ Yes  ☐ No

HOME SAFETY SCREEN
Does your home have throw rugs, poor lighting, or a slippery bathtub or shower?
☐ Yes  ☐ No

RISK FOR FALLS SCREEN
1. Have you fallen in the past year? ☐ Yes  ☐ No

If yes, please answer A and B below:

1a. How many times?
☐ Yes  ☐ No

1b. Were you injured?
☐ Yes  ☐ No

2. Do you feel unsteady when standing or walking?
☐ Yes  ☐ No

3. Do you worry about falling?
☐ Yes  ☐ No

If yes, please answer 4-12 below:

4. Do you use (or were you told to use) a cane or walker to get around safely?
☐ Yes  ☐ No

5. Do you have to steady yourself by holding onto furniture when moving about our home?
☐ Yes  ☐ No

6. Do you need to push with your hands to stand up from a chair?
☐ Yes  ☐ No

7. Do you have trouble stepping up onto a curb?
☐ Yes  ☐ No

8. Do you often have to rush to the toilet?
☐ Yes  ☐ No

9. Have you lost some feeling in your feet?
☐ Yes  ☐ No

10. Do you take any medicine that makes you feel light-headed or tired?
☐ Yes  ☐ No

11. Do you take medicine to help you sleep or improve your mood?
☐ Yes  ☐ No

12. Do you often feel sad or depressed?
☐ Yes  ☐ No
**DIET AND EXERCISE HISTORY**

**How is your appetite?**
- Good
- Fair
- Poor

**Do you eat fewer than two times a day?**
- Yes
- No

**Do you eat at least 2 serving of fruits and vegetables per day?**
- Yes
- No

**How many times per week do you exercise?**
- >3
- 1-3
- 0-1

**INCONTINENCE SCREENING**

**Do you have trouble holding your bowels or bladder?**
- Yes
- No

**ADVANCED CARE PLANNING**

**Do you have an Advanced Directive?**
- Yes
- No

**Have you completed a POLST form?**
- Yes
- No

**Do you have a designated health care representative?**
- Yes
- No

Name/Contact Info

**PHQ-2 DEPRESSION SCREENING**

**Over the last 2 weeks, have you been bothered by any of the following?**

<table>
<thead>
<tr>
<th>Little interest/pleasure in doing things?</th>
<th>Not At All</th>
<th>Several Days</th>
<th>More than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Feeling down, depressed/hopeless?</th>
<th>Not At All</th>
<th>Several Days</th>
<th>More than Half the Days</th>
<th>Nearly Every Day</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**SOCIAL HISTORY QUESTIONS**

**Do you smoke?**
- Yes
- No

If yes, How long? Years: _______ Packs/Day: _______

**Type:** ________________________________

**Do you drink alcohol?**
- Yes
- No

If yes, How many? Per Wk: _______ Per Day: _______

**Are you sexually active?**
- Yes
- No

**Do you have difficulty finding transportation?**
- Yes
- No

**Do you need help preparing or affording meals?**
- Yes
- No

**Do you have difficulty affording your medication(s)?**
- Yes
- No

**Do you have difficulty taking or managing your medication(s)?**
- Yes
- No

**Do you take your medication as prescribed?**
- Yes
- No

Who do you turn to for health/transportation?

- Spouse/Domestic Partner
- Son/Daughter
- Other Family
- Friend
- Neighbor
- Other: ________________________________

Who do you live with?

- Spouse/Domestic Partner
- Alone
- Other: ________________________________
REVIEW OF POTENTIAL RISK FACTORS FOR DEPRESSION

Depression can come from many sources. Here are some potential risk factors your doctor may want to review with you.

- **Genetics**: a family history of depression may increase your risk.
- **Death or loss**: It’s normal to feel sadness or grief from the death of loss of a loved one. But sometimes, this can deepen into depression.
- **Conflict or disputes** with family members and friends may lead to depression.
- **Abuse**: physical, sexual or emotional abuse can be a risk factor for depression.
- **Major events**: retirement, changing jobs, moving, divorce or remarrying, or a major change can increase the risk of developing depression.
- **Serious illness** can bring on depression.
- **Certain medication** side effects can cause depression. Talk with your doctor about the medications you are currently taking.
- **Substance abuse**, such as alcohol, tobacco or illicit substances.
- **Stress** can cause depression.
- **Other personal problems**, such as loneliness can bring on depression.
If you are new to Medicare and this is your initial **MEDICARE ANNUAL WELLNESS VISIT**, please fill out the Medical History, Surgical History and Family History section before your appointment for your **MEDICARE ANNUAL WELLNESS VISIT** so your healthcare provider may review the contents with you.

If you’re an established Medicare patient, please indicate any changes you have had in the past year before your appointment for your **MEDICARE ANNUAL WELLNESS VISIT** so your healthcare provider can review the changes with you. This form will help you organize your information prior to your appointment. Your provider may have a different form to fill out.

If your answer is “Yes” to a question, please explain on the line following the question or in the Notes on the next page.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormal Pap Smear</td>
<td></td>
<td></td>
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<tr>
<td>Anemia</td>
<td></td>
<td></td>
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<tr>
<td>Asthma</td>
<td></td>
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<tr>
<td>Blood Disorder</td>
<td></td>
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<tr>
<td>C.O.P.D.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
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<tr>
<td>Cardiac Arrhythmia</td>
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<tr>
<td>Congestive Heart Failure</td>
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<tr>
<td>Coronary Artery Disease</td>
<td></td>
<td></td>
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<tr>
<td>Depression or Anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elevated Cholesterol</td>
<td></td>
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<tr>
<td>Heart Attack</td>
<td></td>
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<tr>
<td>High Blood Pressure</td>
<td></td>
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<tr>
<td>HIV or AIDS</td>
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<tr>
<td>Implantable Devices</td>
<td></td>
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<tr>
<td>Kidney Problems</td>
<td></td>
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<tr>
<td>Liver Problems</td>
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<tr>
<td>Osteoporosis</td>
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<tr>
<td>Rheumatic Fever</td>
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<tr>
<td>Seizures</td>
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<tr>
<td>Sleep Apnea</td>
<td></td>
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<tr>
<td>Stroke</td>
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<tr>
<td>Thyroid Problems</td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>Other Medical Problems</td>
<td></td>
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<tr>
<td>None/No Changes</td>
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</tbody>
</table>
### Medical & Surgical History

**SURGICAL HISTORY**
If your answer is “Yes” to a question, please explain on the line following the question.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Appendectomy</td>
<td></td>
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<tr>
<td>Breast Surgery</td>
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<tr>
<td>Cholecystectomy (Gall Bladder Surgery)</td>
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<tr>
<td>Eye Surgery</td>
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<tr>
<td>Heart Surgery</td>
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<tr>
<td>Hysterectomy</td>
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<tr>
<td>Joint Replacement</td>
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<tr>
<td>Prostate Surgery</td>
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<tr>
<td>Other Surgical Procedures</td>
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<tr>
<td>None/No Changes</td>
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</tbody>
</table>

**Notes**

________________________________________________________________________________________
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________________________________________________________________________________________
Check off or list any pertinent family medical history.

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Asthma</th>
<th>Cancer/Type</th>
<th>Depression</th>
<th>Diabetes</th>
<th>Heart Disease</th>
<th>Hypertension</th>
<th>High Cholesterol</th>
<th>Stroke</th>
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</thead>
<tbody>
<tr>
<td>Mother</td>
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<td>Father</td>
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<td>Sister</td>
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<td>Brother</td>
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<tr>
<td>Daughter</td>
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<td>Son</td>
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<tr>
<td>Maternal Grandmother (MGM)</td>
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<td>Maternal Grandfather (MGF)</td>
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<td>Paternal Grandmother (PGM)</td>
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<tr>
<td>Paternal Grandfather (PGF)</td>
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Please enter any additional family history below.

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Diagnosis</th>
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<tbody>
<tr>
<td>1.</td>
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<td>6.</td>
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<td>7.</td>
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<td>8.</td>
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</tbody>
</table>
**MEDICATIONS**  □ None/No Medications
Please list all the medications you are taking, including any vitamins, supplements, herbal medicines, and “over-the-counter” medications. Be sure to list all of your medications, dosage (e.g., 10 mg) and frequency (e.g., take twice a day). Please also indicate whether you take this medication always, sometimes, or infrequently. It’s a good idea to bring all your medications with you to your **ANNUAL WELLNESS VISIT** with your doctor.

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Dose</th>
<th>Frequency</th>
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</table>

**ALLERGIES**  □ None/No Allergies
Please list any known allergies to medicines. List all medicines to which you are allergic (e.g., codeine, penicillin, or sulfa drugs).

<table>
<thead>
<tr>
<th>Name of Medication</th>
<th>Type of reaction, such as rash or breathing difficulties</th>
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<tbody>
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</tbody>
</table>

**OTHER KNOWN ALLERGIES**
Please list any other known allergies.

<table>
<thead>
<tr>
<th>Allergy Trigger</th>
<th>Type of reaction, such as rash or breathing difficulties</th>
</tr>
</thead>
<tbody>
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For additional resources, visit california.providence.org or call (888) 432-5464.
### CURRENT DOCTORS, CARE GIVERS AND SUPPLIERS

Having the contact information of those involved in your care will help your doctor in such instances as medical records being needed from your specialists or if an authorization is needed for specialty care. Please list all doctors you have been under treatment with for the past three years. Remember to include your podiatrist, optometrist/ophthalmologist, chiropractor, and any other specialist or physician you typically see. Also, please fill out your preferred pharmacy you use and whether it is retail or mail order.

<table>
<thead>
<tr>
<th>Emergency Contact</th>
<th>Phone</th>
<th>Relationship</th>
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<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Hospital</th>
<th>Phone</th>
<th>Address</th>
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<table>
<thead>
<tr>
<th>Primary Care Physician</th>
<th>Phone</th>
<th>Address</th>
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<table>
<thead>
<tr>
<th>Specialist Name</th>
<th>Specialty</th>
<th>Phone</th>
<th>Address</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Specialist Name</th>
<th>Specialty</th>
<th>Phone</th>
<th>Address</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>[ ] Retail</th>
<th>[ ] Mail Order</th>
<th>Phone</th>
<th>Address</th>
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</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Other</th>
<th>Phone</th>
<th>Address</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Religious Contact</th>
<th>Phone</th>
<th>Address</th>
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<table>
<thead>
<tr>
<th>Neighbor</th>
<th>Phone</th>
<th>Address</th>
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</thead>
<tbody>
<tr>
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</tbody>
</table>
Screening Schedule
DEVELOPMENT OR REVIEW OF A WRITTEN SCREENING SCHEDULE
Your Providence Medical Associates Medicare plan includes many FREE screenings, which help identify disease in early stages. At your **MEDICARE ANNUAL WELLNESS VISIT**, your doctor will help determine which screenings or interventions should be scheduled. Below are some screenings and the approximate frequency. Your doctor will develop a personalized schedule for you.

<table>
<thead>
<tr>
<th>PREVENTIVE CARE</th>
<th>Age</th>
<th>Test Type</th>
<th>Frequency</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Aortic Aneurysm Screening</td>
<td>65-75 years For Smokers Only</td>
<td>Ultrasound</td>
<td>Once</td>
<td></td>
</tr>
<tr>
<td>BMI Assessment</td>
<td>18-75 years</td>
<td>Calculation</td>
<td>Every 2 years</td>
<td></td>
</tr>
<tr>
<td>Breast Cancer Screening Mammogram</td>
<td>50-74 years</td>
<td>Mammogram</td>
<td>Every 2 years</td>
<td></td>
</tr>
<tr>
<td>Cervical &amp; Vaginal Cancer Screenings</td>
<td>21-65 years</td>
<td>Pap Test</td>
<td>Every 3-5 years</td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>50-75 years</td>
<td>Stool Sample</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Colonoscopy</td>
<td>Every 10 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Flexi Sigmoidoscopy</td>
<td>Every 5 years</td>
<td></td>
</tr>
<tr>
<td>DEXA Bone Density Screening</td>
<td>65-120 years</td>
<td>Radiology</td>
<td>Once</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DIABETES CARE</th>
<th>Age</th>
<th>Test Type</th>
<th>Frequency</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive Diabetes Care</td>
<td>18-75 years</td>
<td>Blood Test (Glucose)</td>
<td>Every 6 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urine Sample</td>
<td>Annual</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Blood Pressure Exam</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Eye Exam</td>
<td>Every 2 years</td>
<td></td>
</tr>
<tr>
<td>Appropriate Treatment for Diabetics with Hypertension</td>
<td>18+ years</td>
<td>Prescription</td>
<td>As needed</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LABORATORY DATA</th>
<th>Age</th>
<th>Test Type</th>
<th>Frequency</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glucose</td>
<td>40-70 years</td>
<td>Blood Test</td>
<td>Every 5 years</td>
<td></td>
</tr>
<tr>
<td>Lipid Panel</td>
<td>Female 44-75 years Male 34-75 years</td>
<td>Blood Test</td>
<td>Every 5 years</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IMMUNIZATIONS</th>
<th>Age</th>
<th>Test Type</th>
<th>Frequency</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Herpes Zoster (Zostavax)</td>
<td>60+ years</td>
<td>Shot</td>
<td>Once</td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td>0-120 years</td>
<td>Shot</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>Pneumonia (Pneumovax and Prevnar)</td>
<td>65-120 years</td>
<td>Shot</td>
<td>Once</td>
<td></td>
</tr>
<tr>
<td>Tdap (Tetanus and Diphtheria)</td>
<td>11-120 years</td>
<td>Shot</td>
<td>Every 10 years</td>
<td></td>
</tr>
</tbody>
</table>
# Screening Schedule

<table>
<thead>
<tr>
<th>CARDOVASCULAR CARE</th>
<th>Age</th>
<th>Test Type</th>
<th>Frequency</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Monitoring for Patients on Persistent Medications</td>
<td>18+ years</td>
<td>ARBs and ACEI</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Digoxin</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diuretics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure Control</td>
<td>18-85 years</td>
<td>BP Control</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular Disease (behavioral therapy)</td>
<td>65+ years</td>
<td>Counsel</td>
<td>Annual</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MUSCULOSKELETAL</th>
<th>Age</th>
<th>Test Type</th>
<th>Frequency</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis</td>
<td>18+ years</td>
<td>Prescription</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Osteoporosis Management Bone Density in Women with a Fracture</td>
<td>65-85 years</td>
<td>Radiology</td>
<td>Within 6 months</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HEALTH RISK SCREENING</th>
<th>Age</th>
<th>Test Type</th>
<th>Frequency</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of Generic Prescribing</td>
<td>All Ages</td>
<td>Counsel</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Proportion of Days Covered: Oral Diabetes Medication</td>
<td>18+ years</td>
<td>Counsel</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Proportion of Days Covered: RAS Antagonists</td>
<td>18+ years</td>
<td>Counsel</td>
<td>As needed</td>
<td></td>
</tr>
<tr>
<td>Proportion of Days Covered: Statins</td>
<td>18+ years</td>
<td>Counsel</td>
<td>As needed</td>
<td></td>
</tr>
<tr>
<td>Avoidance of Use of High Risk Medications in Elderly</td>
<td>65+ years</td>
<td>Counsel</td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td>Alcohol Use Counseling</td>
<td>19-120 years</td>
<td>Counsel</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>Tobacco Use Counseling</td>
<td>19-120 years</td>
<td>Counsel</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>Depression Screenings</td>
<td>65+ years</td>
<td>Counsel</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>Hepatitis C Screening Test</td>
<td>Born 1945-1965</td>
<td>Blood Test</td>
<td>Once</td>
<td></td>
</tr>
<tr>
<td>HIV Screening (High Risk)</td>
<td>65+ years</td>
<td>Blood Test</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>Nutrition Therapy Services</td>
<td>65+ years</td>
<td>Counsel</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>Obesity Screening and Counseling</td>
<td>65+ years</td>
<td>Counsel</td>
<td>Annual</td>
<td></td>
</tr>
<tr>
<td>Sexually Transmitted Infections (STI) Screening and Counseling</td>
<td>65+ years</td>
<td>Counsel</td>
<td>Annual</td>
<td></td>
</tr>
</tbody>
</table>
RISK FACTORS AND CONDITIONS
Development (or review) of list of Risk Factors and Conditions for which interventions are recommended or are underway and a list of treatment options and their risks and benefits. Your doctor will review Risk Factors and Conditions to determine which interventions are recommended.

PERSONALIZED HEALTH ADVICE AND REFERRAL
As appropriate to health education or preventive counseling services or programs, or community-based lifestyle interventions to reduce identified risk factors and promote self-management and wellness.

Notes
The following information will help you and the people you love make informed and shared health care decisions for the future. Providence Health & Services believes everyone 18 and older should have an advance directive, which provides key information for your doctor and family.

An advance directive says what kind of medical treatment you want. It says who can make decision for you if you are unable to make them yourself.

Advance directives can be simple or detailed. The information here can help you decide. You can simply name someone to make decisions on your behalf. Or you can include more instructions about treatments such as cardiopulmonary resuscitation (CPR), mechanical ventilation (breathing machine), or insertion of a feeding tube.

Know that if you change your mind about a decision, you can revise your advance directive at any time. It’s never too soon to have a conversation with your family. If you want care that takes into consideration your values, preferences and priorities, then an advance directive can help.

**CHOOSE YOUR HEALTH CARE REPRESENTATIVE**

Name someone you trust to make health care choices for you if you are unable to make your own decisions. Your representative is a family member or friend who:

- Is 18 or older
- Knows you well
- Is willing to accept this responsibility
- Is able to make difficult decisions based on your wishes
- Will communicate effectively with health care providers and family members information you provide in this packet

Your representative **CANNOT** be your doctor or someone who works at the hospital or clinic where you are receiving care, unless he or she is a family member.

Your health care representative can:
- Decide where you will receive care
- Select or dismiss health care providers
- Agree with or say no to medications, tests and treatments
- Say what happens to your body and organs after you die
- Take legal action needed to carry out your wishes

Give a copy of your signed advance directive to your health care representative, family, friends and medical providers.

**YOUR HEALTH CARE REPRESENTATIVE’S AUTHORITY**

Your health care representative can help make the following decisions for various life-support treatments:

**CPR or Cardiopulmonary Resuscitation**

This may involve:
- Pressing hard on your chest to keep your blood pumping
- Electrical shocks to jump-start your heart
- Medicines in your veins

This advance directive is in compliance with the California Probate Code, Section 4671-4675. http://www.leginfo.ca.gov/calaw.html

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With special thanks to the work of Rebecca Sudore, M.D.
Breathing Machine or Ventilator
The machine pumps air into your lungs and breathes for you. You are unable to talk or eat when you are on the machine.

Dialysis
A machine that cleans your blood if your kidneys stop working.

Feeding Tube
A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be inserted surgically.

Blood Transfusions
To put blood in your veins.

End-of-Life Care
If you might die soon, your health care representative can:
- Call a spiritual leader
- Decide if you die at home or in the hospital

Write down any decisions you **DO NOT** want your health care representative to make:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**NAME YOUR HEALTH CARE REPRESENTATIVE**
I want this person to make my medical decisions if I cannot make my own:

________________________________________________________________________

Full name

________________________________________________________________________

Address

City State Zip

Cell/Home phone Work phone

Email Address

________________________________________________________________________

Name Date of birth
Put an X next to the sentence you agree with:

☐ My health care representative will make decisions for me only after I become unable to make my own decisions.

OR

☐ My health care representative can make decisions for me right now, after I sign this form.

How do you want your health care representative to follow your medical wishes? Put an X next to the one sentence you most agree with:

☐ Total flexibility: It is OK for my health care representative to change any of my medical decisions, if after talking with my doctors, he/she thinks it is best for me at that time.

☐ Some flexibility: It is OK for my health care representative to change some of my medical decisions, if, after talking with my doctors, he/she thinks it is best for me at that time.

☐ Minimal flexibility: I want my health care representative to follow my medical wishes as closely as possible. Please respect my decisions, even if doctors recommend otherwise.

These are some of my wishes I particularly want respected:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

MAKE YOUR HEALTH CARE CHOICES
Think about what makes your life worth living. Put an X next to all the sentences you agree with.

☐ My life is always worth living no matter how sick I am.

My life is only worth living if I can:

☐ Communicate with family and friends
☐ Wake up from a coma
☐ Feed, bathe, or take care of myself
☐ Be free from pain
☐ Live without being hooked up to machines
☐ I am not sure

If I am dying, it is important for me to be (choose one):

☐ At home
☐ In a hospital or other care center
☐ It is not important to me where I am cared for

Is religion or spirituality important to you?

☐ No     ☐ Yes

Do you have a religion or faith tradition?

________________________________________________________________________

What should your doctors know about your religious or spiritual beliefs?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Name

Date of birth
LIFE SUPPORT
Life support treatments are used to try to keep you alive. These include CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or medicine. Put an X next to the ONE statement you most agree with.

If I am so sick I may die soon, I would like my health care team to:

☐ Try all life support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, I want to stay on life support machines even if I am suffering.

☐ Try all life support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better I do NOT want to stay on life support machines. If I am suffering, I want to stop and be allowed to die gently.

☐ I do not want life support treatments even if my doctors think they might help. I want to focus on being comfortable. I prefer to have a natural death.

☐ I want my health care representative to decide for me.

☐ I am not sure.

What other wishes are important to you?

________________________________________________________________________

MAKE YOUR HEALTH CARE CHOICES
Your doctors may ask about organ donation and an autopsy after you die.

Donating Your Organs
Put an X next to the one choice you most agree with. Donating your organs can help save lives.

☐ I want to donate my organs

Which organs to you want to donate?

☐ any organ

☐ only:

☐ I do not want to donate my organs.

☐ I want my health care representative to decide.

☐ I am not sure.

Autopsy
An autopsy can be done after death to find out why someone died. It’s a surgical procedure. It can take a few days.

☐ I want an autopsy.

☐ I do not want an autopsy.

☐ I only want an autopsy if there are questions about the cause(s) of my death.

☐ I want my health care representative to decide.

☐ I am not sure.

________________________________________________________________________
SIGN THE FORM
Before this form can be used, you must:
• Sign this form if you are at least 18
• Have two witnesses sign the form or have it notarized by a notary public, see page 24

Sign your name and write the date.

Signature ______________________ Date ______

Print Name ______________________

Address ______________________ City, State Zip

Name ______________________ Date of birth ______
**WITNESSES**

Before this form can be used, you must have two witnesses sign the form or notary public. If you live in a skilled nursing facility, you must have the ombudsman sign as well.

**Your witnesses must:**
- Be at least 18
- Know you
- See you sign this form

**Your witnesses cannot:**
- Be the person you named as your health care representative
- Be related to you in any way (must be true for at least one witness)
- Be your doctor or other health care provider
- Work for your medical center or health care provider
- Be related to you in any way (must be true for at least one witness)
- Work at the place that you live (if you live in a skilled nursing facility, see bottom of Page 24)
- Benefit financially – eligible for any money or property – after you die (must be true for at least one witness)
- Work at the place that you live (if you live in a skilled nursing facility, see bottom of Page 24)
- Be related to you in any way (must be true for at least one witness)

If you do not have two witnesses, a notary public can sign on Page 24.

**Have your witnesses complete this page.**

By signing, I promise that I saw ________________________________ sign this form.

Name

He/she was thinking clearly and was not forced to sign this form.

**I also promise that:**
- I know this person and he/she could prove who he/she was
- I am at least 18
- I am not his/her health care representative
- I am in no way related to him/her (must be true for at least one witness)
- I will not benefit financially – eligible for any money or property – after he/she dies (must be true for at least one witness)

<table>
<thead>
<tr>
<th>Witness #1 Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print Name</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>City, State</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Witness #2 Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print Name</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>City, State</td>
</tr>
</tbody>
</table>

**Name**

**Date of birth**
Advance Directive

NOTARY PUBLIC
Take this form to a notary public ONLY if two witnesses have not signed. Bring photo I.D. (driver’s license, passport, etc.).

State of California
County of ___________________________________________________ On ____________________________

before me,______________________________________________________________________________________________
personally appeared ____________________________________________________________
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _________________________________________

Description of Attached Document

Title or Type of document: _____________________________

Date: ________________________ Number of pages: ______

Capacity(ies) Claimed by Signer(s)

Signer’s Name: _____________________________________

☐ Individual

☐ Guardian or conservator

☐ Other _____________________________________________

FOR CALIFORNIA SKILLED NURSING FACILITY RESIDENTS ONLY
Give this form to your nursing home director ONLY if you live in a nursing home. California law requires nursing home residents to have the nursing home ombudsman as a witness of advance directives.

Statement of the patient advocate or ombudsman
“I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.”

Signature _______________________________ Date ______________________

Print Name ____________________________________________________________

Address ____________________________________________________________________

City, State Zip ____________________________________________________________________
HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

A  CARDIOPULMONARY RESUSCITATION (CPR):
- If patient has no pulse and is not breathing.
- If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

☐ Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)
☐ Do Not Attempt Resuscitation/DNR (Allow Natural Death)

B  MEDICAL INTERVENTIONS:
- If patient is found with a pulse and/or is breathing.

☐ Full Treatment – primary goal of prolonging life by all medically effective means.
- In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
- Trial Period of Full Treatment.

☐ Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.
- In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
- Request transfer to hospital only if comfort needs cannot be met in current location.

☐ Comfort-Focused Treatment – primary goal of maximizing comfort.
- Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location.

Additional Orders: ____________________________________________________________

C  ARTIFICIALLY ADMINISTERED NUTRITION:
- Offer food by mouth if feasible and desired.

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: ____________________________
☐ Trial period of artificial nutrition, including feeding tubes. ____________________________
☐ No artificial means of nutrition, including feeding tubes. ____________________________

D  INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated ________, available and reviewed → Healthcare Agent if named in Advance Directive:
☐ Advance Directive not available
☐ No Advance Directive
  Name: ____________________________________________
  Phone: ____________________________________________

Signature of Physician
My signature below indicates to the best of my knowledge that these orders are consistent with the patient’s medical condition and preferences.

Print Physician Name: ____________________________ Physician Phone Number: ____________________________ Physician License Number: ____________________________

Physician Signature: (required) ____________________________ Date: ____________________________

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the patient who is the subject of the form.

Print Name: ____________________________________________ Relationship: (write self if patient) ____________________________ Date: ____________________________

Signature: (required) ____________________________________________ Phone Number: ____________________________
Mailing Address (street/city/state/zip): ____________________________ Phone Number: ____________________________ Office Use Only: ____________________________
HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

Patient Information
Name (last, first, middle): Date of Birth: Gender: M F

Healthcare Provider Assisting with Form Preparation
☐ N/A if POLST is completed by signing physician
Name: Title: Phone Number:

Additional Contact
☐ None
Name: Relationship to Patient: Phone Number:

Directions for Healthcare Provider

Completing POLST
- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a healthcare provider based on patient preferences and medical indications.
- A legally recognized decisionmaker can include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in the patient's medical record, on Ultra Pink paper when possible.

Using POLST
- Any incomplete section of POLST implies full treatment for that section.

*Section A:*
- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen “Do Not Attempt Resuscitation.”

*Section B:*
- When comfort cannot be achieved in the current setting, the patient, including someone with “Comfort-Focused Treatment,” should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not “Comfort-Focused Treatment.”
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate “Selective Treatment” or “Full Treatment.”
- Depending on local EMS protocol, “Additional Orders” written in Section B may not be implemented by EMS personnel.

Reviewing POLST
It is recommended that POLST be reviewed periodically. Review is recommended when:
- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST
- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing “VOID” in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force. For more information or a copy of the form, visit [www.caPOLST.org](http://www.caPOLST.org).

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED