SLU Annual Medicare Wellness Visit

Nursing Home _____

Name_____ DOB___/___/_____ Date____/____/_____

Vital Signs: Ht____Wt_____ B/P_____/____ Pulse_____ RR_____

Vaccinations:		Date
Influenza	Y / N	___/___/_____
Pneumococcus	Y / N	___/___/_____
Prevnar	Y / N	___/___/_____
Tetanus	Y / N	___/___/_____

		Date
Hepatitis B	Y / N	___/___/_____
Herpes Zoster	Y / N	___/___/_____
PPD	Y / N	___/___/_____

Active Diseases:
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Medications:
1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____
10._____
11._____
12._____
13._____
14._____

PHQ 9 _____ Hearing Impaired Y/ N
FRAIL _____ Cerumen impacted Y / N
FRAIL NH___ Vision Impaired Y / N
Pain Score____ Falls Y / N
SARC-F_____ Smoking Y/N
SNAQ _____ Weight Loss Y/N
RCS _____ Advance Directive Y / N

A Scale to Identify Frailty in the Nursing Home - FRAIL NH Scale

	0	1	2
Fatigue	No	Yes	PHQ-9 ≥10
Resistance (Transfer)	Independent Transfer	Set Up	Physical Help
Ambulation	Independent	Assistive Device	Not Able
Incontinence	None	Bladder	Bowel
Loss of Weight	None	≥5% in 3 mo.	≥10% in 6 mo.
Nutritional Approach	Regular Diet	Mechanically Altered	Feeding Tube
Help with Dressing	Independent	Set Up	Physical Help
Total			0-14

Assessment: Patient had annual wellness visit. Agree with findings. Pt is cognitively intact / impaired, not frail, not falling, not disabled. Pt and/or family counseled.

Recommendations:_____

Signature_____ G0439