blue california
Promise Health Plan

Health Risk Assessment Progress Note

Name: DOB: Age: HICN: Date:

RISK ASSESSMENT				
SUBJECT	Y	N	**If yes, then:**	**Comments:**
Has patient been to the ER in the past 6 months?			How many times?	
Has patient been admitted in the past 12 months?			How many times?	
Has patient been in a skilled nursing facility in the past 12 months?			Where?	
Has patient been receiving Home Health Care (PT, OT, Nurse)?			What agency?	
Is patient currently receiving Hospice services?			What agency?	
Does patient have or use durable medical equipment at home?			What equipment?	
Does patient require any type of medical supplies?			What Supplies?	
Does the patient currently see any specialists?			What Specialists?	
Does the patient live alone?				
Does the patient have help at home?			Explain:	
Has the patient fallen in the past 6 months?			How many times?	
Does the patient have any skin breakdown?			Location & severity?	
Is patient currently on dialysis?			Where?	
Is patient hearing impaired?				
Are there safety issues at home?			Describe:	
Is the patient currently being treated by a Behavioral Health Care Provider?			Who?	
Is the patient sexually active?				

Does the patient have any of the following conditions (specify Dx below)?

□ Renal Disease	□ CHF	□ Vision Problems	□ Transplant
□ Back Problems	□ Diabetes	□ Seizures	□ Other? If so, describe:
□ Cancer	□ HIV/AIDS	□ GI Problems	
□ Chronic Pain	□ Lung Problems (COPD, Asthma)	□ Sudden Weight Change	

Does the patient have any of the following behavioral health conditions (specify Dx below)?

□ Anxiety	□ Drug Abuse	□ Attention-Deficit Hyperactivity Disorder
□ Depression	□ Smoking	□ Suicidal ideation
□ Alcohol Abuse	□ Dementia	□ Other (Describe):

Past Family Medical and Personal Surgical History:

Medication Review Status		**Comments/Clinical Recommendations**
Reviewed and documented list of current medications, dosage, and last refill date? ☐ Yes **(Must Attach Meds List)** ☐ No	**Drug Allergies or Sensitivities?** ☐ **Yes** ☐ **No known allergies**	**Changes?** ☐ **Yes** ☐ **No**

Advance Directive: □ Discussed ☐ Signed Advance Directive/HealthCare Power of Attorney

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Last First MI

FUNCTIONAL ASSESSMENT		
ACTIVITY	**SCORE**	**COMMENTS**
FEEDING 0 = unable 5 = needs help cutting, spreading butter, etc., or requires modified diet 10 = independent		
BATHING 0 = dependent 5 = independent (or in shower)		
GROOMING 0 = needs help with personal care 5 = independent face/hair/teeth/shaving		
DRESSING 0 = dependent 5 = needs help but can do about half unaided 10 = independent (including buttons, zips, laces, etc.)		
BOWELS 0 = incontinent (or needs to be given enemas) 5 = occasional accident 10 = continent		
BLADDER 0 = incontinent (or catheterized and unable to manage alone) 5 = occasional accident 10 = continent		
TOILET USE 0 = dependent 5 = needs some help, but can do something alone 10 = independent (on and off, dressing, wiping)		
TRANSFERS (BED TO CHAIR AND BACK) 0 = unable, no sitting balance 5 = major help (one or two people, physical), can sit 10 = minor help (verbal or physical) 15 = independent		
MOBILITY (ON LEVEL SURFACES) 0 = immobile or <50 yards 5 = wheelchair independent, including corners, >50 yards 10 = walks with help of one person (verbal or physical), >50 yards 15 = independent (but may use aid; for example, stick) >50 yards		
STAIRS 0 = unable 5 = needs help (verbal, physical, carrying aid) 10 = independent		
TOTAL FUNCTIONAL SCORE (0–100):		

PAIN SCALES
(circle the indicator that best describes pain level from any one of the Scale types below)

Numerical Scale	0	□1	2	3	4	5	6	7	8	9	10
Verbal Scale	No Pain	Mild Pain		Moderate Pain				Severe Pain			Worst Possible
Activity Scale	No Pain	Can Be Ignored		Interferes with Tasks		Interferes with Concentration		Interferes with Basic Needs			Bed rest Required

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Last First MI

Depression Screening Tool PHQ – 9:

In the past 2 weeks, how often have you been bothered by:

Over the last two weeks, how often have you been bothered by any of the following?	Not at all (=0)	Several days (=1)	More than half the days (=2)	Nearly everyday (=3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or over-eating				
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you been moving a lot more than usual.				
9. Thoughts that you are better off dead, or hurting yourself in some way				
Column Totals:				
Total Score:				

10. If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ **Not difficult at all** ☐ **Somewhat difficult** ☐ **Very difficult** ☐ **Extremely difficult**

OFFICE: Using the Total Score above, refer to PHQ-9 Score Table and Guidelines and apply appropriate code:

PHQ-9 Diagnosis code: ____________________

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Health Maintenance Assessment:

Preventive Care	Completed	Date of Service
Pneumonia Vaccine	☐ Yes ☐ No ☐ Unk	
Flu Vaccine	☐ Yes ☐ No ☐ Unk	
A1c Testing value: ____________	☐ Yes ☐ No ☐ Unk	
GRF, estimated (serum creatinine)result: ____________________ Coding Chronic Kidney Disease Stages: _Stage 4 (585.4): 2 eGFR 15-29 at least 3mos apart; _Stage 5/Renal failure (585.5): eGFR <15 / dialysis _Stage 6/ESRD (585.6): _V45.11 Dialysis Status Is patient on dialysis? Yes ☐ No ☐ Unk ☐	☐ Yes ☐ No ☐ Unk	
Retinal Exam _ non-proliferative retinopathy (362.01) _ proliferative retinopathy (362.02) _ vitreous hemorrhage (379.23)	☐ Yes ☐ No ☐ Unk	
Glaucoma Testing	☐ Yes ☐ No ☐ Unk	
Any fractures in the last 12 months? If yes, have you been dx with Osteoporosis? If yes, is the patient on treatment?	☐ Yes ☐ No ☐ Unk ☐ Yes ☐ No ☐ Unk ☐ Yes ☐ No ☐ Unk	
Colon Cancer Screening - If yes, indicate type of screening test: ☐ FOBT ☐ Sigmoidoscopy ☐ Colonoscopy Provider Name:	☐ Yes ☐ No ☐ Unk	
Mammogram Screening - If yes: Provider Name:	☐ Yes ☐ No ☐ Unk	
History of Mastectomy - If yes: ☐ Right ☐ Left ☐ Bilateral Note Provider Name:	☐ Yes ☐ No ☐ Unk	

Did you get any lab work done in the last 6 – 12 months? ☐ **Yes** ☐ **No**

Did the PCP review the lab results with you within 2 weeks of getting the results? ☐ **Yes** ☐ **No**

Assessment of Current Conditions

KEY: N= New E= Existing S= Stable I = Improving W = Worsening

Diagnosis:	Assessment:	Findings/Plan	Diagnosis:	Assessment:	Findings/Plan
Onset Date:	☐ N ☐ E ☐ S ☐ I ☐ W		Onset Date:	☐ N ☐ E ☐ S ☐ I ☐ W	
Diagnosis: Onset Date:	Assessment: ☐ N ☐ E ☐ S ☐ I ☐ W	Findings/Plan	Diagnosis: Onset Date:	Assessment: ☐ N ☐ E ☐ S ☐ I ☐ W	Findings/Plan
Diagnosis: Onset Date:	Assessment: ☐ N ☐ E ☐ S ☐ I ☐ W	Findings/Plan	Diagnosis: Onset Date:	Assessment: ☐ N ☐ E ☐ S ☐ I ☐ W	Findings/Plan

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Last First MI

PHYSICAL EXAMINATION

Does the patient appear well nourished and not in distress? ☐ Yes ☐ No Describe:______________________

Weight:_____Height:_______Calculated BMI:________Pulse:_______ /min____ Resp:_____ /min___Temp:______

Vitals: BP ____/____ mmHg Repeated BP ___/____mmHg (Repeat after 15 minutes if Syst > 140 and/or Dias is > 90)

System	Findings	Normal
HEENT	(No lesions-symmetrical; PERRLA, conjunctivae & sclerae clear; Vision grossly norma; Canals clear, TM's normal, hearing grossly normal; Passages clear, MM pink; no masses, no septal deviation, thyroid not enlarged, etc.)	☐ Yes ☐ No
Vision	(Assess visual changes, movement of ocular muscles, etc.)	☐ Yes ☐ No
Cardiovascular System	(Look for Heart sounds, murmurs, pacemakers, regular rate and rhythm, normal S1, S2, etc.)	☐ Yes ☐ No
Respiratory System	(Evaluate breath sounds, presence/absence of ronchi and crepts, tracheostomy, etc.)	☐ Yes ☐ No
Abdomen/ Pelvis	(Evaluate for any swellings, guarding, tenderness, enlarged liver/spleen, lymph nodes, etc.)	☐ Yes ☐ No
Breast (female only)	(Evaluate for any swellings, tenderness, lymph nodes, etc.)	☐ Yes ☐ No
Musculo-skeletal	(Evaluate for any pain, swellings, joint tenderness, range of movement, etc.; No cyanosis, clubbing or edema)	☐ Yes ☐ No
Neurological	(Evaluate gait, speech, muscle strength, reflexes, etc. Non focal, CN II-XII WNL)	☐ Yes ☐ No
Skin	(Evaluate for ulcers, pigmentation, swellings, etc.)	☐ Yes ☐ No
Sensory exam	(Evaluate for position/temperature senses, fine touch, decreased senses in extremities, etc.)	☐ Yes ☐ No
Other Findings:		

Health Education:	**Referrals:**	**Next F/U Appt:**
Print Provider Name and Credentials:		
Provider Signature and Credentials:		**Date:**