To: **Our Medicare Patients:**

Subject: **Medicare Annual Wellness and Other Preventive Visits**

Beginning January 1, 2011, Medicare covers an “Annual Wellness Visit” in addition to the one-time “Welcome to Medicare” exam. The “Welcome to Medicare” exam occurs only once during your first twelve months as a Medicare patient. You may receive your Annual Wellness Visit after you have been with Medicare for more than one year, or it has been at least one year since your “Welcome to Medicare” exam.

Initial Preventive Physical Exam (IPPE)	“Welcome to Medicare” is only for *new* Medicare patients. This must be done in the 1st year as a Medicare patient.
Annual Wellness Visit, Initial	At least 1 yr after the “Welcome to Medicare” exam.
Annual Wellness Visit, Subsequent	Once a year (more than 1 yr + 1 day after the last Wellness Visit).

The Annual Wellness Visit is not the same thing as what many people often refer to as their yearly physical exam. Medicare is very specific about what the “Annual Wellness Visit” includes and excludes.

At the Annual Wellness Visit, your doctor will talk to you about your medical history, review your risk factors, and make a personalized prevention plan to keep you healthy. The visit does *not* include a hands-on exam or any testing that your doctor may recommend, nor does it include any discussion about any new or current medical problems, conditions, or medications. You may schedule another visit to address those issues *or* your doctor may charge the usual Medicare fees for such services that are beyond the scope of the Annual Wellness Visit.

If you would like to schedule an annual physical, including any lab work or other diagnostic testing, medication management, vaccinations, and other services, please understand that these services will be charged and covered according to Medicare’s usual coverage guidelines. However, you may still develop a care plan based on the Annual Wellness Visit criteria.

We appreciate the trust you put in us to take care of your health care needs and hope that you will take advantage of this new benefit to work with your physician in creating your personalized prevention plan.

See the attached list to bring with you to your appointment.

What you should bring to your Annual Wellness Visit:

The names of all your doctors:

Name	Specialty

A list of all your medications

Name of medicine	Dose	How medication is taken (1 daily, PRN)

Have you had any tests done in the past year? ___ Yes ___ No
(Such as blood tests, colonoscopy, mammograms, x-rays, CT scan, MRI, etc.)

Test Name	Date

Have you had any recent immunizations? ___ Yes ___ No
Do you have a *Living Will* or *Advance Directive*? ___ Yes ___ No
(If you have one, *please bring a copy of it with you*.)

Health Risk Assessment

Patient Name: ________________________________ DOB: ___________________ Date: _____________

1. Can you get places out of walking distance without help?
*For example, can you travel alone by bus, taxi, or drive your own car?

Yes ☐
No ☐

2. Can you shop for groceries or clothes without help?

Yes ☐
No ☐

3. Can you prepare your own meals?

Yes ☐
No ☐

4. Can you do your own housework without help?

Yes ☐
No ☐

5. Can you handle your own money without help?

Yes ☐
No ☐

6. Do you need help eating, bathing, dressing, or getting around your home?

Yes ☐
No ☐

7. Are you having difficulties driving your car?

No ☐
Sometimes ☐
Yes, often ☐
Not applicable, I do not use a car ☐

8. Have you been given any information to help you keep track of your medications?

Yes ☐
No ☐

9. How often do you have trouble taking medicines the way you have been told to take them?

I do not have to take medicine ☐
I always take them as prescribed ☐
Sometimes I take them as prescribed ☐
I seldom take them as prescribed ☐

10. During the past 4 weeks, was someone available to help you if you needed and wanted help? *For example, if you felt very nervous, lonely or blue, got sick and had to stay in bed, needed someone to talk to, needed help with daily chores, or needed help just taking care of yourself.

Yes, as much as I wanted ☐
Yes, quite a bit ☐
Yes, some ☐
Yes, a little ☐
No, not at all ☐

11. How often in the past 4 weeks, have you had trouble eating well?

Never ☐
Seldom ☐
Sometimes ☐
Often ☐
Always ☐

12. How often in the past 4 weeks, have you been bothered by your teeth or dentures?

Never ☐
Seldom ☐
Sometimes ☐
Often ☐
Always ☐

13. How often in the past 4 weeks, have you had problems using the telephone?

Never ☐
Seldom ☐
Sometimes ☐
Often ☐
Always ☐

Patient Name: _______________________________ DOB: __________________ Date: ____________

14. Have you been given any information to help you identify hazards in your house that might hurt you?

Yes ☐
No ☐

15. Do you always fasten your seatbelt when you are in a car?

Yes, Usually ☐
Yes, Sometimes ☐
No ☐

16. Have you had sex in the past 12 months (vaginal, oral or anal)?

Yes ☐
No ☐

17. Have you ever had a sexually transmitted disease?

Yes ☐
No ☐

18. During the past 4 weeks, how much bodily pain have you generally had?

No pain ☐
Very mild pain ☐
Mild pain ☐
Moderate pain ☐
Sever pain ☐

19. During the past 4 weeks, what was the hardest physical activity you could do for at least 2 minutes?

Very heavy ☐
Heavy ☐
Moderate ☐
Light ☐
Very light ☐

20. During the past 4 weeks, how would you rate your general health?

Excellent ☐
Very good ☐
Good ☐
Fair ☐
Poor ☐

21. How have things been going for you in the past 4 weeks?

Very well – could hardly be better ☐
Pretty good ☐
Good and bad are about equal ☐
Pretty bad ☐
Very bad – could hardly be worse ☐

22. How confident are you that you can control and manage most of your health problems?

Very confident ☐
Somewhat confident ☐
Not very confident ☐
I do not have any health problems ☐

23. Over the past 2 weeks, have you experienced having little interest or pleasure in doing things?

Yes ☐
No ☐

24. Over the past 2 weeks, have you been feeling down, depressed or hopeless?

Yes ☐
No ☐

25. Are you a smoker?

No ☐
Yes, and I might quit ☐
Yes, but I am not ready to quit ☐

Patient Name: ________________________________ DOB: __________________ Date: ____________

26. Did you have a drink containing alcohol in the past year?

Yes □

No □

27. Have you fallen two (2) or more times in the past year?

Yes □

No □

28. Were you injured in any falls in the past year?

Yes □

No □

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ____ DATE: _________________________

Over the past 2 weeks, how often have you been bothered by any of the following problems? (use "✓" to indicate your answer)	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
1. Little interest or please in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself… or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. 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	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
Add Columns		______ +	______ +	______

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card)

TOTAL: ______________________

10. If you checked off any problems, how difficult have these problems made if 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 ________

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