MEDICARE WELLNESS VISIT

Name:________________________________ DOB:_____________ DATE: ___/___/___

SCREENING FOR DEPRESSION

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle answer)	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
Feeling down, depressed, or hopeless	**0**	**1**	**2**	**3**
Trouble falling or staying asleep, or sleeping too much	**0**	**1**	**2**	**3**
Feeling tired or having little energy	**0**	**1**	**2**	**3**
Poor appetite or overeating	**0**	**1**	**2**	**3**
Feeling bad about yourself — or that you are a failure	**0**	**1**	**2**	**3**
Trouble concentrating on things, daily activities	**0**	**1**	**2**	**3**
Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless	**0**	**1**	**2**	**3**
Thoughts that you would be better off dead	**0**	**1**	**2**	**3**
		Total Score		

0 to 4= Minimal depression (may not need treatment)
5-9= Mild depression;10-14= Moderate depression (clinical judgment of physician to treat)
15-19= Moderately severe depression; 20-27= Severe depression (treatment warranted)

HEARING SCREENING

	Yes (4 pts)	Sometimes (2 pts)	No (0 pts)
Does a hearing problem cause you to feel embarrassed when you meet new people?			
Does hearing problem cause you to feel frustrated when talking to your family?			
Do you have difficulty hearing when someone speaks in a whisper?			
Do you feel handicapped by a hearing problem?			
Does a hearing problem cause you to attend religious services less often ?			
Does a hearing problem cause you to have arguments with family members?			
Does a hearing problem cause you difficulty when listening to TV or radio?			
Do you feel that any difficulty with you hearing limits your personal or social life?			
Does a hearing problem cause you difficulty when in a restaurant with friends?			
Does a hearing problem cause difficulty when visiting friends, relatives, or neighbors?			

0 to 8= 13% probability of hearing impairment (no handicap/no referral)
10 to 24= 50% probability of hearing impairment (mild-moderate handicap/refer)
26 to 40= 84 % probability of hearing impairment (severe handicap/refer)

FUNCTIONAL STATUS SCREENING

Due to a health or memory problem do you have any difficulty with bathing or showering?	YES	NO
Due to a health or memory problem do you have any difficulty with managing your money ?	YES	NO
Due to a health problem do you have any difficulty with walking several blocks?	YES	NO
Due to a health problem do you have any difficulty with pulling or pushing large objects ?	YES	NO
Due to a health or memory problem do you have any difficulty dressing yourself?	YES	NO
Due to a health or memory problem do you have any difficulty with toileting ? Incontinence?	YES	NO

HOME SAFETY SCREENING

Are emergency numbers kept by the phone and regularly updated?	YES	NO
Are all household members aware of the dangers of smoking, especially in bed?	YES	NO
Are firearms stored unloaded and securely locked?	YES	NO
Are working smoke alarm(s) and fire extinguisher(s) available for use?	YES	NO
Do all household members know how to use them?	YES	NO
Have throw rugs been removed or fastened down?	YES	NO
Are all electrical cords in working order, easily seen ?	YES	NO
Are non-slip mats in all bathtubs and showers?	YES	NO

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Do all stairways have a railing or banister?	YES	NO
Are doorways, halls, and stairs free of clutter?	YES	NO
Are sidewalks and all outdoor steps clear of tools, toys, and other articles?	YES	NO

URINARY INCONTINCENCE

Do you frequently get up at night to urinate?	YES	NO
Do you wet your pants or your bed?	YES	NO
Have you ever had burning or pains when you urinate?	YES	NO
Do you have a constant feeling that you have to urinate?	YES	NO
Do you have difficulty starting your urine flow?	YES	NO

ADVANCE MEDICAL DIRECTIVE

Do you have an Advance Medical Directive?	YES	NO
Do you have a Do Not Resuscitate Order?		

HEPATITIS C SCREENING

Have you ever had a Hepatitis C Screening?	YES	NO
Were you born between the years 1945-1965?	YES	NO
Have you had a blood transfusion before 1992?	YES	NO
Have you previously OR are you currently injecting illicit drugs?	YES	NO

--------------------------------------to be completed by the Provider--

FALL RISK SCREENING

1 Have your ever been treated for falls? . . . . Y N

Perform the Get Up and Go Test

THE TEST:

- Patient should stand up from chair, walk 10 feet, turn around, and walk back to chair.
- Assistive devices permitted.

THE RESULTS: American Geriatric Society defines "fail" as > 30 seconds.

COGNITIVE SCREEN

Interview may repeat names 3 times if necessary but repetition not score.

1	What years is this?	Correct	Incorrect
2	What month is this?	Correct	Incorrect
3	What is the day of the week?	Correct	Incorrect

What were the three objects I asked you to remember?

4	Apple?	Correct	Incorrect
5	Table?	Correct	Incorrect
6	Penny?	Correct	Incorrect