MARLBORO INTERNALMEDICINE
RELATIONSHIP ■ RESPECT ■ RESULTS

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To: **Our Medicare Patients**

Subject: **Medicare Annual Wellness and Other Preventative 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 Preventative 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 year after** the "Welcome to Medicare" exam.
Annual Wellness Visit, Subsequent	**Once a year** (more than 1 year and 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 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.

****Attached you will find three forms. Please complete the first two prior to your upcoming appointment. The third form is for your provider to complete. Thank you and we look forward to serving you.****

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MEDICARE WELLNESS VISIT PATIENT HEALTH RISK ASSESSMENT QUESTIONNAIRE

Name of Patient: _____ **DOB:** _____

Do you have any health concerns or NEW complaints you would like to address today? Yes___ No___

_____
_____
_____

Past Medical/Surgical History: *(List illnesses, injuries, operations, hospitalizations, date and hospital)*

_____
_____
_____

Please list your current healthcare providers involved in your care and condition treated: *(Specialists, Therapists, VNA, etc.)*

_____
_____
_____

Are there any preventative tests you have done recently? *(Lab tests, Mammograms, X-rays, etc.)*

_____
_____
_____

Have you had any recent immunizations?

_____
_____
_____

Do you have a health Care Proxy?

_____
_____
_____

General Health and Social/Emotional Support:

In general, would you say your health is: Excellent___ Very Good___ Good___ Fair___ Poor___
Does handling such things as your health, finances, family or social relationships or work cause you stress? Yes___ No___
Do you get the social and emotional support you need? Yes___ No___
Do you snore or has anyone told you that you snore? Yes___ No___
Do you always fasten your seatbelt when you are in a car? Yes___ No___

Social History:

Do you use tobacco? Yes___ No___
Do you use alcohol? Yes___ No___

Depression Screen:

Over the past 2 weeks, have you felt down, depressed or hopeless? Yes___ No___
Over the past 2 weeks, have you felt little interest or pleasure in doing things? Yes___ No___

Hearing Loss Screen:

Do you have trouble hearing the television or radio when others do not? Yes___ No___
Do you have to strain or struggle to hear/understand conversations? Yes___ No___

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Name of Patient: _____ **Date:** _____

Function Screen:

Do you need help with everyday activities such as eating, getting dressed, grooming, bathing, walking or using the toilet?	Yes___ No___
Do you need help preparing meals, transportation, shopping, taking your medicine, banking, managing your finances, or other daily activities?	Yes___ No___
Do you live alone?	Yes___ No___
Do you feel you have trouble with memory?	Yes___ No___
Do you ever have leakage or urine?	Yes___ No___

Home Safety Screen:

Does your home have throw rugs, poor lighting, or a slippery bathtub/shower?	Yes___ No___
Does your home have grab bars in the bathroom, handrails on the steps or stairs?	Yes___ No___
Does your home have functioning smoke alarms?	Yes___ No___

Nutrition:

Do you eat 3-5 servings of fruits/vegetables every day?	Yes___ No___
Do you eat 3-5 servings of high-fiber or whole grain foods daily? *(whole wheat bread, cooked cereal, brown rice, or whole wheat pasta)*	Yes___ No___
Do you eat more than one serving of fried or high-fat foods daily? *(fried meat or fish, french fries, potato chips, foods made with whole milk cream cheese or mayonnaise)*	Yes___ No___

Nutrition:

Do you get light (stretching or slow walking) or moderate (brisk walking) exercise at least 3 times per week?	Yes___ No___

Form Completed by:

_____ _____

Relationship