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
Resistance (Transfer)	Independent Transfer	Set Up	Physical Help
Ambulation	Independent	Assistive Device	Not Able
Incontinence	None	Bladder	Bowel
Loss of Weight	None		
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