



SLU Annual Medicare Wellness Visit

Nursing Home _____

Name _____ DOB ___/___/___ Date ___/___/___

Vital Signs: Ht ___ Wt ___ B/P ___/___/___ Pulse ___ RR ___

Vaccinations:

	<u>Date</u>		<u>Date</u>
Influenza	Y / N ___/___/___	Hepatitis B	Y / N ___/___/___
Pneumococcus	Y / N ___/___/___	Herpes Zoster	Y / N ___/___/___
Pevnar	Y / N ___/___/___	PPD	Y / N ___/___/___
Tetanus	Y / N ___/___/___		

Date

Hepatitis B	Y / N ___/___/___
Herpes Zoster	Y / N ___/___/___
PPD	Y / N ___/___/___

Active Diseases:

- _____
- _____
- _____
- _____
- _____
- _____
- _____

Medications:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

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 _____

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