Annual Care for Older Adults (COA) Form

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Read Carefully

This form must be completed and signed by the provider. Please save a copy in the patient's medical records.

Patient Name: ______________________ **DOB:** _____/_____/______ **ID #:** ________________

Date Vitals Collected: _____/_____/______ **Blood Pressure:** _______/_______

Height: __________ **Weight:** __________ **BMI:** __________

Functional Status Assessment (CPT II: 1170F)

Date Assessed: _____/_____/______ **ADLs Assessed?** ☐ **Yes** ☐ **No** **iADLs Assessed?** ☐ **Yes** ☐ **No**

Was a FSA tool used: ☐ **Yes** ☐ **No** **If YES, name of FSA tool** ______________________

Score/Result __________________

Pain Assessment (CPT II: 1125F, 1126F)

Date Assessed: _____/_____/______ **Does the patient have pain?** ☐ **Yes** ☐ **No**

Medication List and Review (CPT II: 1159F and 1160F)

Attach the member's medication list OR document all prescriptions, over-the-counter and herbal supplements below.

Date Reviewed: _____/_____/______ **Medication List attached:** ☐

Patient not taking any medications: ☐

Medication/Dosage/Frequency	Medication/Dosage/Frequency

Provider Name (Print): ______________________________________

Credentials: ☐ **MD** ☐ **DO** ☐ **NP** ☐ **PA** ☐ **PharmD** ☐ **Other:** ______________________

Provider Signature: ______________________________ **Date:** _____/_____/______

If the form is filled out by an office or clinical support staff member, it must route back to the provider for follow-up and sign off.

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Advance Care Planning (ACP) Form

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This form must be completed and signed by the provider. Please save a copy in the patient's medical records.

Patient Name: ______________________________ **DOB:** _____ /_____ /______ **ID #:** _________________

Advance Care Planning (CPT II: 1123F, 1124F, 1157F, 1158F)
Date discussed with Patient/Caregiver: _____ /_____ /______
Copy of Advance Care Plan in patient's chart: ☐ **Yes** ☐ **No**
Patient has: ☐ Advance Directives ☐ Surrogate Decision Maker ☐ Living Will ☐ Actionable Medical Orders

Provider Name (Print): ____

Credentials: ☐ **MD** ☐ **DO** ☐ **NP** ☐ **PA** ☐ **PharmD** ☐ **Other:** ____________________________

Provider Signature: ____ **Date:** _____ /_____ /______

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