# Annual Care for Older Adults (COA) Form

## 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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PRO_100761E Internal Approved 07052022

# Advance Care Planning (ACP) Form

## 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 #:** _____

| **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:** _____/_____/_____

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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