

Patient Name: _____

DOB: _____ Assessment Date: _____

Diagnosis	Active	Resolved
Head and Neck		
Epilepsy or Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Severe Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular		
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
With CHF	<input type="checkbox"/>	<input type="checkbox"/>
With CKD Stage: _____	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
Atrial Fibrillation	<input type="checkbox"/>	<input type="checkbox"/>
Atrial Flutter	<input type="checkbox"/>	<input type="checkbox"/>
Cardiomyopathy	<input type="checkbox"/>	<input type="checkbox"/>
Acute Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>
With Stable Angina	<input type="checkbox"/>	<input type="checkbox"/>
With Unstable Angina	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerosis of Extremities with Ulceration or Gangrene	<input type="checkbox"/>	<input type="checkbox"/>
CVA	<input type="checkbox"/>	<input type="checkbox"/>
Hemiplegia/Hemiplegia	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Disease with Complications	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Disease without Complications	<input type="checkbox"/>	<input type="checkbox"/>
Severe Hematological Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary		
Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>
Aspiration / Specified Bacterial Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Respirator Dependence	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen		
Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>
End Stage Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Renal		
Acute Renal Failure	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stage: _____	<input type="checkbox"/>	<input type="checkbox"/>
Dialysis Status	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal		
Fracture (Within Past Year)	<input type="checkbox"/>	<input type="checkbox"/>
Site: _____	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Cord Disorder/Injury	<input type="checkbox"/>	<input type="checkbox"/>
Quadriplegia	<input type="checkbox"/>	<input type="checkbox"/>
Paraplegia	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

Diagnosis	Active	Resolved
Skin-Integumentary		
Pressure ulcer of skin with necrosis through to muscle, tendon or bone	<input type="checkbox"/>	<input type="checkbox"/>
Pressure ulcer of skin with full thickness skin loss	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine		
Diabetes Type: _____	<input type="checkbox"/>	<input type="checkbox"/>
With CKD, Stage: _____	<input type="checkbox"/>	<input type="checkbox"/>
With Peripheral Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
With Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
With Retinopathy	<input type="checkbox"/>	<input type="checkbox"/>
With Other Complications	<input type="checkbox"/>	<input type="checkbox"/>
Without Complications	<input type="checkbox"/>	<input type="checkbox"/>
Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Cancer		
Brain or Nervous System Tumors	<input type="checkbox"/>	<input type="checkbox"/>
Breast	<input type="checkbox"/>	<input type="checkbox"/>
Prostate	<input type="checkbox"/>	<input type="checkbox"/>
Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Colorectal	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Acute	<input type="checkbox"/>	<input type="checkbox"/>
Chronic	<input type="checkbox"/>	<input type="checkbox"/>
Lung	<input type="checkbox"/>	<input type="checkbox"/>
Metastatic Cancer (Specify): _____	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Infectious Diseases		
HIV	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Hepatitis Type: _____	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Health		
Dementia	<input type="checkbox"/>	<input type="checkbox"/>
Mild Depression	<input type="checkbox"/>	<input type="checkbox"/>
Severe Depression	<input type="checkbox"/>	<input type="checkbox"/>
Drug/Alcohol Psychosis / Dependence	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Other		
Morbid Obesity (BMI ≥ 40)	<input type="checkbox"/>	<input type="checkbox"/>
Malnutrition	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>
Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Huntington's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Monoplegia and Other Paralytic Syndromes	<input type="checkbox"/>	<input type="checkbox"/>
Sepsis	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name: _____

DOB: _____

Assessment Date: _____

Family Medical History				
Cancer	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Grandparents	<input type="checkbox"/> Sibling
Diabetes	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Grandparents	<input type="checkbox"/> Sibling
Heart Disease	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Grandparents	<input type="checkbox"/> Sibling
Hypertension	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Grandparents	<input type="checkbox"/> Sibling
Other: _____	<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Grandparents	<input type="checkbox"/> Sibling

Physical Exam							
Height: Ft: _____ In: _____	Weight: _____ Lbs.		BMI: _____		<input type="checkbox"/> Unable to Obtain BMI		
Resp: _____ /Min	Pulse: _____ /Min		O2 Sat: _____		Blood Pressure: Sys: _____ Dias: _____		
				Temp: _____ °F			
	Within Normal Limits (NL)	Abnormal (AB)	Findings / Specify AB		Within Normal Limits (NL)	Abnormal (AB)	Findings / Specify AB
General Appearance	<input type="checkbox"/> NL	<input type="checkbox"/> AB		Lymphatic	<input type="checkbox"/> NL	<input type="checkbox"/> AB	
HENT	<input type="checkbox"/> NL	<input type="checkbox"/> AB		Musculoskeletal	<input type="checkbox"/> NL	<input type="checkbox"/> AB	
Eyes	<input type="checkbox"/> NL	<input type="checkbox"/> AB		Skin	<input type="checkbox"/> NL	<input type="checkbox"/> AB	
Cardiovascular	<input type="checkbox"/> NL	<input type="checkbox"/> AB		Neurological	<input type="checkbox"/> NL	<input type="checkbox"/> AB	
Pulmonary	<input type="checkbox"/> NL	<input type="checkbox"/> AB		Genitourinary	<input type="checkbox"/> NL	<input type="checkbox"/> AB	
Chest/Breast	<input type="checkbox"/> NL	<input type="checkbox"/> AB		Other: _____	<input type="checkbox"/> NL	<input type="checkbox"/> AB	
Gastrointestinal	<input type="checkbox"/> NL	<input type="checkbox"/> AB					

Diagnosis/Assessment	Treatment Plan							Specify/Explain
1	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other		
2	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other		
3	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other		
4	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other		
5	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other		
6	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other		
7	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other		
8	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other		
9	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other		
10	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other		
11	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other		
12	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other		
13	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other		
14	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other		
15	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other:		
16	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other:		
17	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other:		
18	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other:		
19	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other:		
20	<input type="checkbox"/> Medication	<input type="checkbox"/> Monitor	<input type="checkbox"/> Diet	<input type="checkbox"/> Labs	<input type="checkbox"/> Referrals	<input type="checkbox"/> Other:		

Patient Name: _____

DOB: _____

Assessment Date: _____

Preventive Services		
Breast Cancer Screening (Women age 50-74)		
<input type="checkbox"/> Mammogram performed within 27 months prior to December 31 of the current year		Date: _____
<input type="checkbox"/> Excluded due to Bilateral Mastectomy		Date: _____
<input type="checkbox"/> Excluded due to Two Unilateral Mastectomies	Date: _____	Date: _____
<input type="checkbox"/> Screening not applicable due to patient outside the age range or male		
Colorectal Cancer Screening (Patients age 50-75)		
<input type="checkbox"/> Colonoscopy performed this year or in the nine years prior		Date: _____
<input type="checkbox"/> CT Colonography performed this year or in the 4 years prior		Date: _____
<input type="checkbox"/> Flexible sigmoidoscopy performed this year or in the 4 years prior		Date: _____
<input type="checkbox"/> FIT-DNA test performed this year or in the 2 years prior		Date: _____
<input type="checkbox"/> Fecal occult blood test (FOBT) or FIT test performed this year (cannot be from sample collected in provider office)		Date: _____
<input type="checkbox"/> Excluded due to Total Colectomy		Date: _____
<input type="checkbox"/> Excluded due to diagnosis of Colorectal Cancer		Date: _____
<input type="checkbox"/> Screening not applicable due to patient outside the age range		
Condition Management		
Comprehensive Diabetes Care (Diabetic Patients age 18-75)		
Nephropathy		
<input type="checkbox"/> Urine test for albumin or protein		Date: _____
<input type="checkbox"/> ACE/ARB therapy this year	Medication Name/Dosage: _____	Date: _____
<input type="checkbox"/> Visit with Nephrologist this year	Result: _____	Date: _____
<input type="checkbox"/> Evidence of Renal Transplant		Date: _____
<input type="checkbox"/> Evidence of Stage 4 Chronic Kidney Disease		Date: _____
<input type="checkbox"/> Evidence of End Stage Renal Disease		Date: _____
Retinal Eye Exam		
<input type="checkbox"/> Retinal or Dilated Eye Exam by an Optometrist or Ophthalmologist this year	Result: _____	Date: _____
<input type="checkbox"/> Name of Optometry or Ophthalmology Provider: _____		
<input type="checkbox"/> NEGATIVE Retinal or Dilated Eye Exam by an Optometrist or Ophthalmologist in the previous year		Date: _____
<input type="checkbox"/> Bilateral Eye Enucleation anytime in the patient's history		Date: _____
HbA1c		
<input type="checkbox"/> HbA1c test this year	Result: _____	Date: _____
Statin Use		
<input type="checkbox"/> Medication Prescribed: _____		Date: _____
<input type="checkbox"/> Excluded due to diagnosis of Gestational Diabetes this year or in the previous year		Date: _____
<input type="checkbox"/> Excluded due to diagnosis of Steroid-Induced Diabetes this year or in the previous year		Date: _____
<input type="checkbox"/> Screenings not applicable due to patient outside the age range or not diabetic		
Osteoporosis Management in Women with a Fracture (Women age 67-85 with fracture in the past year excluding fractures of finger, toe, face and skull)		
Fracture Date: _____		
<input type="checkbox"/> Bone Mineral Density Testing completed within six months after the fracture		Date: _____
<input type="checkbox"/> Osteoporosis medication was prescribed or taken within six months after the fracture		Date: _____
<input type="checkbox"/> Excluded due to Bone Mineral Density Testing completed within 24 months prior to the fracture		Date: _____
<input type="checkbox"/> Excluded due to Osteoporosis Therapy within 12 months prior to the fracture		Date: _____
<input type="checkbox"/> Screening not applicable due to patient outside the age range or did not have a fracture		
Rheumatoid Arthritis (Patients with Diagnosis of Rheumatoid Arthritis)		
<input type="checkbox"/> Prescribed or current DMARD treatment this year. Name of Medication: _____		Date: _____
<input type="checkbox"/> Excluded due to pregnancy this year		Date: _____
<input type="checkbox"/> Excluded due to diagnosis of HIV		Date: _____
<input type="checkbox"/> Diagnosis not substantiated		
<input type="checkbox"/> Screening not applicable due to no diagnosis of Rheumatoid Arthritis		

Patient Name: _____

DOB: _____

Assessment Date: _____

Additional Tests	
<input type="checkbox"/> Prostate Cancer Screening	Date: _____
<input type="checkbox"/> Pap/Pelvic Exam (Age 21 to 65)	Date: _____
<input type="checkbox"/> Other: _____	Date: _____
<input type="checkbox"/> Results	Date: _____

Current Vaccinations		
<input type="checkbox"/> Influenza: Last Date: _____	<input type="checkbox"/> Series of 3 Hep B vaccinations completed: Date: _____	<input type="checkbox"/> Tetanus: Last Date: _____
<input type="checkbox"/> Pneumococcal: <input type="checkbox"/> PCV13/Prevnar®: Date: _____	<input type="checkbox"/> PPSV23/Pneumovax®: Date: _____	
<input type="checkbox"/> Shingles: <input type="checkbox"/> Zostavax®: Date: _____ <input type="checkbox"/> Shingrix: Date of First Dose: _____ Date of Second Dose: _____		

Social History				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does patient exercise? If yes, how often? _____ Type of Exercise: _____		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does patient drink alcohol? If yes, how much? _____ Type of Alcohol: _____		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does patient drink caffeine? If yes, how much? _____		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does patient currently use tobacco? If yes: # of years used: _____ Type of Tobacco: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Chew <input type="checkbox"/> Pipe <input type="checkbox"/> Cigar How often? _____ If no: <input type="checkbox"/> Never used or Year Quit: _____		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does patient use illegal drugs or drugs for which they were not prescribed? If yes: Type: _____ How Used: _____ # of years using: _____		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does patient use shared needles?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has patient received a blood transfusion prior to 1985?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has patient obtained a tattoo?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If more than one sexual partner, does patient use protection from sexually transmitted infections?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does patient wear seatbelt?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Can patient read and/or write?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does patient live alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does patient have caregiver or family support to assist with ADLs?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has a vision assessment been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is patient blind or have severe vision impairment?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has a hearing assessment been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Does patient have a hearing impairment? If yes, does patient wear a hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No

Other Specialist Providers Caring for this Patient			
Name	Specialty	Name	Specialty

Functional Status Assessment	
Please select if any of the following assessments have been completed:	
<input type="checkbox"/> Assessment of basic activities of daily living (ADLs), such as <input type="checkbox"/> bathing, <input type="checkbox"/> dressing, <input type="checkbox"/> eating, <input type="checkbox"/> transferring, <input type="checkbox"/> using toilet, <input type="checkbox"/> walking	Date: _____
<input type="checkbox"/> Assessment of instrumental ADLs such as <input type="checkbox"/> meal preparation, <input type="checkbox"/> shopping for groceries, <input type="checkbox"/> using public transportation, <input type="checkbox"/> housework, <input type="checkbox"/> home repair, <input type="checkbox"/> laundry, <input type="checkbox"/> taking medications or <input type="checkbox"/> handling finances	Date: _____
<input type="checkbox"/> Results using a standardized functional status assessment tool Name of tool: _____	Date: _____
<input type="checkbox"/> Assessment of three of the following four components: <input type="checkbox"/> cognitive status; <input type="checkbox"/> ambulation status; <input type="checkbox"/> sensory ability; <input type="checkbox"/> other functional independence, such as <input type="checkbox"/> exercise, <input type="checkbox"/> ability to perform job	Date: _____

Fall Risk Assessment		Depression Screening	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has a fall risk assessment been completed?	
If yes, tool used: <input type="checkbox"/> STEADI <input type="checkbox"/> Morse Fall Risk Assessment <input type="checkbox"/> Hendrich Fall Risk Assessment <input type="checkbox"/> Other: _____		If yes, tool used: <input type="checkbox"/> PHQ-2 <input type="checkbox"/> PHQ-9 <input type="checkbox"/> Other: _____	
Results: _____ (Attach results/tool, if available)		Results: _____	
Date: _____		Date: _____	
Date: _____ (Attach results/tool, if available)		Date: _____ (Attach results/tool, if available)	
Note: Assessment/Screening Tools are available at http://www.bcbst.com/providers/quality-initiatives/Provider-Assessment-Form-Resources.page			

Patient Name: _____

DOB: _____

Assessment Date: _____

Healthy Days Measurement
In the past 30 days, in regards to physical health, which includes physical illness and injury, how many days was physical health not good? <input type="checkbox"/> 1-4 days <input type="checkbox"/> 5-14 days <input type="checkbox"/> 15-30 days <input type="checkbox"/> None
In the past 30 days, how many days did physical or mental health interrupt usual activities, such as self-care, work, or recreation? <input type="checkbox"/> 1-4 days <input type="checkbox"/> 5-14 days <input type="checkbox"/> 15-30 days <input type="checkbox"/> None

Pain Assessment	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does patient suffer from chronic pain?
If yes, where is pain located? _____	<input type="checkbox"/> Acute <input type="checkbox"/> Chronic
How does patient rate their pain? (Zero is no pain; 10 is extreme pain) <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10	Is patient in pain management? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of assessment: _____	

Cognitive Assessment	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has a cognitive assessment been completed?
Date of assessment: _____	
If yes, tool used: <input type="checkbox"/> Mini-Cog <input type="checkbox"/> GPCOG <input type="checkbox"/> MIS <input type="checkbox"/> Other: _____	
Results: _____ (Attach results/tool, if available)	
Note: Cognitive Assessment Tool is available at http://www.bcbst.com/providers/quality-initiatives/Provider-Assessment-Form-Resources.page	

Medical Case Management	
<input type="checkbox"/>	Refer to BlueCross Medical Case Management
Reason: _____	

Behavioral Health Case Management	
<input type="checkbox"/>	Refer to BlueCross Behavioral Health Case Management
Reason: _____	

Member Stratification Level	<input type="checkbox"/> Level/Low	<input type="checkbox"/> Level/High
-----------------------------	------------------------------------	-------------------------------------

ICT Team members

Member Plan of Care developed with Care Coordination team

PCP revisions/additions to Plan of Care

Provider Name and Credentials (printed): _____

Date: _____

Provider Signature: _____

NPI: _____

(Must be completed and signed by MD, DO, PA or NP)