Medicare Annual Wellness Visit (AWV) Note Template

Method of Completion: Telehealth encounter or Office Visit (circle one)

Patient Name: _____ **DOB:** _____ **Date:** _____

Subjective:

Patient presents to the clinic today for: **AWV initial / AWV Subsequent** (circle one)

_____

Medical History: _____

Family History: _____

Social History: _____

Care Team: _____

Allergies: _____

Current Medications: _____

Immunizations Up To Date? Yes/No (circle) _____

Hospitalizations in the Past year? Yes/No (circle, if yes, explain) _____

Urinary incontinence, leakage of urine or unusual urinary frequency? Yes/No (circle, if yes, explain) _____

Living will/Advanced Directive? Yes/No (circle) _____

Functional Ability/Safety/Cognitive Impairment:

Patient or family noticed forgetfulness? Yes/No (circle, if yes, explain) _____

Mental Health (PHQ-9) _____Mini-Cog_____

Domestic violence or Care giver abuse? Yes/No (circle, if yes, explain) _____

Ability to successfully perform ADL's? Yes/No (circle, if no, explain) _____

Home safety risk factors identified? Yes/No (circle, if yes, explain) _____

Any falls in last year? Yes/No (circle, if yes, explain) _____

Issues with balance or walking in the last year? Yes/No (circle, if yes, explain) _____

Lifestyle Review:

Healthy Eating Habits? Yes/No _____Special Diet? Yes/No_____

Exercise/Type _____How many times a week? _____

Other: _____

Preventive Exams/Screenings:

Colonoscopy: _____ Mammogram: _____ Bone Density: _____

U/S AAA: _____ PSA: _____ PAP: _____ Lung Cancer CT: _____

Tobacco: _____ Depression: _____ Alcohol Misuse: _____

Vision Exam: _____ Dental Exam: _____ Hearing Exam: _____

Other: _____

Assessment	Results
Smoking Status	Never/Quit/Cur. Smoker (circle) PPD_____ Yrs. _____ Yr. Quit _____
PHQ-9 (abnormal: >/= 10)	Score:
Mini-Cog (abnormal: </= 3)	Score:
AUDIT-C (abnormal: >/= 4 Male, >/= 3 Female)	Score:
Health Risk Assessment Concerns	Yes/No (circle)
Advanced Directive? (request copy to have in file)	Yes/No (circle)
Hearing Screening	Result:

Objective: *Were vitals reported by patient during a telehealth encounter? Yes/No* (circle)

HT: _____ WT: _____ BMI: _____ BP: _____/_____ P: _____ Resp: _____

Other: _____

Assessment and Plan:

Wellness assessment positive findings: _____

_____

_____

Recommendations and follow up: _____

_____

_____

Immunizations recommended: _____

Patient Handouts			
	Balance Exercises		Brain Exercises
	Healthy Diet		Urinary Abnormalities
	Personalized Action Plan (including schedule of preventive services, referrals and guidance)		Other:

During the course of the visit the patient was educated and counseled about appropriate screening and preventive services. Any exceptions listed here: _____

Communication barriers and lifestyle preferences were addressed with the patient. The care plan including medications and self-management goals were reviewed to the best of the patient's abilities. All questions and concerns were answered. Patient and/or family verbalized understanding of the plan of care.

Provider Signature: _____ Date: _____