

Today's Date: _____

Patient Name: _____



Annual Wellness Visit Health Risk Assessment

Personal Information

1. Preferred Pharmacy: _____
2. Preferred Lab: _____
3. Preferred imaging and x-ray facility: _____

Care Team

Specialty	Physician Name	Last Seen
Cardiology		
Dentist		
Dermatologist		
Ear, Nose & Throat (ENT)		
Endocrinologist		
Eye/Optometry/Ophthalmologist		
Gastroenterologist		
Gynecologist		
Hematologist/Oncologist		
Nephrologist		
Neurologist		
Orthopedist		
Podiatrist		
Pulmonologist		
Psychiatrist/Psychologist		
Rheumatologist		
Urologist		
Other:		

Have you seen a dentist within the last 6 months:	Yes	No
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Pain Assessment

In the past 2 weeks, how often have you felt pain?

Never	Almost never	Sometimes	Most times	Almost all of the time
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Where is the pain? _____

Rate your pain on the following scale:

1 😊 | 2 😊 | 3 😊 | 4 😊 | 5 😊 | 6 😊 | 7 😊 | 8 😊 | 9 😊 | 10 😊

Allergies – Drugs, Food Environment

Medications – Prescriptions, Vitamins, Over-the-Counter

Name	Dose	Name	Dose

Self & Family History *(mark the columns that apply)*

	None	Self	Parent	Brother	Sister	Child
Congestive Heart Failure						
Diabetes						
COPD (Chronic Lung Disease) or Asthma						
Hypertension						
Stroke						
Kidney Disease						
Obesity						
Liver Disease						
Bipolar Disorder or Schizophrenia						
Dementia						
Cancer						
Depression						
Significant Surgeries:						

Functional Status Assessment

Are you able to care for yourself independently?	Yes	No	Note:
Are you blind or do you have difficulty seeing?	Yes	No	Note:
Are you use eyeglasses or contacts?	Yes	No	Note:
Are you deaf or have serious difficulty hearing?	Yes	No	Note:
Do you use hearing aids or other devices?	Yes	No	Note:
Do you have difficulty concentrating, remembering or making decisions?	Yes	No	Note:
Do you have difficulty walking or climbing stairs?	Yes	No	Note:
Do you have difficulty dressing, bathing, grooming or toileting?	Yes	No	Note:
Do you have difficulty doing errands alone?	Yes	No	Note:
Do you have transportation difficulties?	Yes	No	Note:

Physical Activity

How many days a week do you exercise?	0	1-2	3-4	5+	I don't know
How intense is your exercise?	Light	Moderate	Heavy	Very Heavy	I don't know I don't exercise

Tobacco, Alcohol and Drug Use

Do you use any tobacco products? (Cigarettes, chew, snuff, pipes, cigar)	Yes	No
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If so, are you interested in quitting tobacco?	Yes	No	I don't use tobacco
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How many times in the past year have you had 4 or more drinks in a day?	Never	Moderate	Heavy	Number of days:
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Do you use any illegal drugs or take any prescription medications that have not been prescribed to you?	No	Yes (please describe):
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Advance Directives

Does your family or friends know what you want in an emergency situation or if you could not speak for yourself:

No | Yes and I have completed (mark all that apply):

<input type="checkbox"/>	A living will (Advance Directive)
<input type="checkbox"/>	DNR
<input type="checkbox"/>	Power of Attorney for Health Care
<input type="checkbox"/>	POLST (in some states known as: POST, MOST, MOSLST, TPOPP)
<input type="checkbox"/>	Five wishes

Would you like more information?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
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Home/Safety

What is your housing situation like? (mark all that apply):

<input type="checkbox"/>	Live with one or more children or dependent
<input type="checkbox"/>	Live in an assisted living facility
<input type="checkbox"/>	Live alone
<input type="checkbox"/>	I have housing today, but I am worried about losing housing in the future
<input type="checkbox"/>	I do not have housing (I am staying with others, on a beach, in a car, abandoned building, bus or train station or in a park

Social/Emotional Support

Which of the following applies to you? (mark all that apply):

<input type="checkbox"/>	I have a supportive family
<input type="checkbox"/>	I have supportive friends
<input type="checkbox"/>	I participate in church, clubs, or other groups
<input type="checkbox"/>	None

Would you like more information?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unsure
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Sleep

How many hours of sleep do you usually get?	0-3	4-6	7-10	I don't know
Do you snore, or has anyone told you that you snore?	Yes	No	I don't know	
In the past 7 days, how often have you felt sleepy during the day?	Often	Sometimes	Almost Never	Never
Have you ever been diagnosed with Sleep Apnea or other sleep disorders?	Yes	No	I don't know	
Are you currently using or have you used C-PAP/Bi-PAP?	Yes	No		

Depression Screening (PHQ-2)

In the past 2 weeks, how often have you been bothered by the following problems:	Not at all	Several Days:	More than half of those days:	Nearly every day:
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

Total Score: _____

Steady Fall Risk *(mark all that apply):*

Yes	No	
		I have fallen in the past year
		I use or have been advised to use a can or walker to get around safely
		Sometimes I feel unsteady when I am walking
		I steady myself by holding onto furniture when walking at home
		I am worried about falling
		I need to push with my hands to stand up from a chair
		I have some trouble stepping up onto a curb
		I often have to rush to the toilet
		I have lost some feeling in my feet
		I take medicine that sometimes makes me feel light-headed or more tired than usual
		I take medicine to help me sleep or improve my mood
		I often feel sad or depressed

Total Score: _____

Do you have a problem with the following at your home? *(mark all that apply):*

	Bug infestation		
	Mold		
	Lead pain or pipes		
	Inadequate heat		
	Oven or stove not working		
	No or not working smoke detectors		
	Water leaks		
	None of the above		
Do you feel safe in your home?	Yes	No	
Does your home have working smoke alarms?	Yes	No	I don't know
Do you have area rugs on your floor(s)?	Yes	No	
Do you have handrails in the bathroom?	Yes	No	
Do you have proper lighting in your home?	Yes	No	
Do you have handrails for the stairs?	Yes	No	I don't have stairs
Do you fasten your seatbelt in vehicles?	Yes	No	I don't ride in vehicles

AD8 Dementia Screening Interview

Patient ID#: _____

CS ID#: _____

Date: _____

Remember, "Yes, a change" indicates that there has been a change in the last several years caused by cognitive (thinking and memory) problems.	YES, A change	NO, No change	N/A, Don't know
1. Problems with judgment (e.g., problems making decisions, bad financial decisions, problems with thinking)			
2. Less interest in hobbies/activities			
3. Repeats the same things over and over (questions, stories, or statements)			
4. Trouble learning how to use a tool, appliance, or gadget (e.g., VCR, computer, microwave, remote control)			
5. Forgets correct month or year			
6. Trouble handling complicated financial affairs (e.g., balancing checkbook, income taxes, paying bills)			
7. Trouble remembering appointments			
8. Daily problems with thinking and/or memory			
TOTAL AD8 SCORE			

Urinary Incontinence Questionnaire ICIQ-SF

1 How often do you leak urine? (Check one box).

	Never	<input type="checkbox"/>	0
	About once a week or less often	<input type="checkbox"/>	1
	two or three times a week	<input type="checkbox"/>	2
	about once a day	<input type="checkbox"/>	3
	several times a day	<input type="checkbox"/>	4
	all the time	<input type="checkbox"/>	5

2 We would like to know how much urine you think leaks.

How much urine do you usually leak (whether you wear protection or not)? (Check one box).

	None	<input type="checkbox"/>	0
	A small amount	<input type="checkbox"/>	2
	A moderate amount	<input type="checkbox"/>	4
	A large amount	<input type="checkbox"/>	6

3 Overall, how much does leaking urine interfere with your everyday life?

Please circle a number between 0 (not at all) and 10 (a great deal).

0	1	2	3	4	5	6	7	8	9	10
Not at all										A great deal

ICIQ score: sum scores 1+2+3: _____

4 When does urine leak? (Please check all that apply to you).

	Never - urine does not leak	<input type="checkbox"/>
	Leaks before you can get to the bathroom	<input type="checkbox"/>
	Leaks when you cough or sneeze	<input type="checkbox"/>
	Leaks when you are asleep	<input type="checkbox"/>
	Leaks when you are physically active/exercising	<input type="checkbox"/>
	Leaks when you have finished urinating and are dressed	<input type="checkbox"/>
	Leaks for no obvious reason	<input type="checkbox"/>
	Leaks all the time	<input type="checkbox"/>

Thank you very much for answering these questions.



EMSA #111 B
(Effective 4/1/2017)*

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: (optional)

A <i>Check One</i>	CARDIOPULMONARY RESUSCITATION (CPR): <i>If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.</i>
	<input type="checkbox"/> Attempt Resuscitation/CPR (Selecting CPR in Section A <u>requires</u> selecting Full Treatment in Section B) <input type="checkbox"/> Do Not Attempt Resuscitation/DNR (Allow <u>N</u> atural <u>D</u> eath)

B <i>Check One</i>	MEDICAL INTERVENTIONS: <i>If patient is found with a pulse and/or is breathing.</i>
	<input type="checkbox"/> Full Treatment – primary goal of prolonging life by all medically effective means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. <input type="checkbox"/> <i>Trial Period of Full Treatment.</i> <input type="checkbox"/> Selective Treatment – goal of treating medical conditions while avoiding burdensome measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. <input type="checkbox"/> <i>Request transfer to hospital <u>only</u> if comfort needs cannot be met in current location.</i> <input type="checkbox"/> Comfort-Focused Treatment – primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. <i>Request transfer to hospital <u>only</u> if comfort needs cannot be met in current location.</i> Additional Orders: _____ _____

C <i>Check One</i>	ARTIFICIALLY ADMINISTERED NUTRITION: <i>Offer food by mouth if feasible and desired.</i>
	<input type="checkbox"/> Long-term artificial nutrition, including feeding tubes. Additional Orders: _____ <input type="checkbox"/> Trial period of artificial nutrition, including feeding tubes. _____ <input type="checkbox"/> No artificial means of nutrition, including feeding tubes. _____

D	INFORMATION AND SIGNATURES:	
	Discussed with:	<input type="checkbox"/> Patient (Patient Has Capacity) <input type="checkbox"/> Legally Recognized Decisionmaker
	<input type="checkbox"/> Advance Directive dated _____, available and reviewed → <input type="checkbox"/> Advance Directive not available <input type="checkbox"/> No Advance Directive	Health Care Agent if named in Advance Directive: Name: _____ Phone: _____
	Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)	
	My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.	
	Print Physician/NP/PA Name:	Physician/NP/PA Phone #: Physician/PA License #, NP Cert. #:
	Physician/NP/PA Signature: (required)	
	Date:	
	Signature of Patient or Legally Recognized Decisionmaker	
	I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.	
Print Name:	Relationship: (write self if patient)	
Signature: (required)	Date:	
Mailing Address (street/city/state/zip):	Phone Number:	
Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.		

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011, 10/1/2014 or 01/01/2016 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F
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NP/PA's Supervising Physician

Name:	Preparer Name (if other than signing Physician/NP/PA) Name/Title:	Phone #:
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Additional Contact

 None

Name:	Relationship to Patient:	Phone #:
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Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit www.caPOLST.org.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED