

**General Assessment**

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| Member Name: | **UCare** Number: |
| Click here to enter text. | Click here to enter text. |
| **DOB:** | **UCare Product:** | Date Completed: |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |

**Health History**

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| **Hospitalizations in last 12 months**  |
| **Number:** **Please describe**: Click here to enter text. |
| **ER Visits in last 12 months**  |
| **Number** **Please describe**: Click here to enter text. |
| Do you have any of the following health conditions?  |
| **Neurological**: [ ]  Yes [ ]  No If yes, what? Click here to enter text. | **Cardiac**: [ ]  Yes [ ]  No If yes, what? Click here to enter text. |
| **Respiratory**: [ ]  Yes [ ]  No If yes, what? Click here to enter text. | **GI**: [ ]  Yes [ ]  No If yes, what? Click here to enter text. |
| **Endocrine**: [ ]  Yes [ ]  No If yes, what? Click here to enter text. | **Orthopedic**: [ ]  Yes [ ]  No If yes, what? Click here to enter text. |
| **Renal**: [ ]  Yes [ ]  No If yes, what? Click here to enter text. | **Autoimmune**: [ ]  Yes [ ]  No If yes, what? Click here to enter text. |
| **Other:** [ ]  Yes [ ]  No If yes, what? Click here to enter text. |

**Preventative Care**

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| **Have you had any of the following tests or exams within the last 12 months?** | **If No, would you like your****CM to assist scheduling?** |
| **Annual Physical or wellness exam?** Choose an item.**Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **Dental Exam?** Choose an item.**Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **Vision Exam?** Choose an item.**Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **Mammogram?** Choose an item.**Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **Prostate Exam or PSA test?** Choose an item.**Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **Colorectal screening?** Choose an item.**Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **Flu Shot?** Choose an item.**Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **Pneumonia Shot?** Choose an item.**Comments** Click here to enter text. | **Yes** [ ]  **No** [ ]  |
| **For members with diabetes only.****Have you had any of the following tests within the last 12 months?** | **If No, would you like** **CM to assist scheduling?** |
| **A1C test?** Choose an item.**Kidney function (nephropathy) test?** Choose an item.**Comments** Click here to enter text. | **Yes** [ ]  **No** [ ] **Yes** [ ]  **No** [ ]  |

**Activities of Daily Living**

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| **Do you need assistance with any of the following (check all that apply). If yes, please describe needs.** |
| [ ]  **Ambulating/transferring** [ ]  **Grooming** [ ]  **Dressing** [ ]  **Bathing** [ ]  **Going to the bathroom** [ ]  **Meal Preparation** [ ]  **Eating****Comments:** Click here to enter text. |

**Home Safety**

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| **Do you feel safe within your current living arrangement?** [ ]  Yes [ ]  No [ ]  Chose not to answer* **If no, list circumstances:** Click here to enter text.
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| **Do you have any safety concerns about your living arrangement?** *(i.e. cords, rugs, stairs)*[ ]  Yes [ ]  No [ ]  Chose not to answer* **If yes, describe**: Click here to enter text.
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| **Have you fallen in the past 12 months?**[ ]  Yes [ ]  No [ ]  Chose not to answer**Comments:** Click here to enter text. |

**Medications *(Prescribed and Over-the-counter)***

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| **Please list all medications and supplements you are taking. Include name, dose and frequency taken.**  |
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| **How do you organize your medications?** *(i.e. med box, dispenser, etc.)*Click here to enter text.**Do you ever miss doses of your medications?** [ ]  Yes [ ]  No [ ]  Chose not to answer **If yes, please explain why:** Click here to enter text. |

**Advanced Directives**

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| **Do you have any of the following in place? *(Check all that apply)*** |
| [ ]  Advance Directives [ ]  Living Will [ ]  Durable Power of Attorney for Health Care [ ]  Durable Power of Attorney for Financial**If none of the above were listed, was a discussion about Advance Directives completed?**   [ ]  Yes [ ]  No* **If no, why not?** Click here to enter text.

**Additional Comments**: Click here to enter text.  |

**Case Manager Signature: Date:** Click here to enter a date.

**Type CM Name and Credentials:**Click here to enter text.