BlueCare Plus Tennessee

1 Cameron Hill Circle
Chattanooga, TN 37402

BlueCare Plus (HMO SNP)SM Patient Assessment and Care Planning Form

BlueCare Plus Fax: **1-423-591-9504**

Please fill out form Completely

Name:		DOB:	Assessment Date:
☐Male ☐ Female	☐ Married ☐ Single ☐ Divorced ☐ Widowed	Spouse/Caregiver Name:	Member ID:
Email Address:		Ethnicity:	Medicare #:

Does patient have an Advance Directive? ☐ Yes ☐ No

If yes, which one(s)? ☐ Living Will ☐ Power of Attorney ☐Other:_____

If no, have Advance Directives been discussed? ☐ Yes ☐ No

Allergies ☐ None

Name of Medication/Allergen	Reaction	Name of Medication/Allergen	Reaction
1.		3.	
2.		4.	

Hospitalizations (Past Year) ☐ None

Dates (estimate)	Reason	Medication Reconciliation completed within 30 Days (Date)	Medication Reconciliation completed by (Provider/ Prescriber/Pharmacist/RN)

Past Surgical History (e.g., tonsillectomy, appendectomy, gallbladder, etc.) ☐ None

☐ Amputation	5.	9.
☐ Colostomy	6.	10.
☐ Tracheostomy	7.	11.
☐ Transplant	8.	12.

Current Medications (e.g., prescription, diet, herbs, vitamins, over-the-counter medications) ☐ None

Name of Medication	Dose/Strength	Frequency	Prescribed by	Indications

Medication Review

Medication List Reviewed For:					Specify/Explain
☐ Yes	☐ No	Drug-Drug Interactions			
☐ Yes	☐ No	High Risk Medications			
		☐ Yes	☐ No	Opioids	
		☐ Yes	☐ No	Aspirin	
		☐ Yes	☐ No	Sleeping Meds	
		☐ Yes	☐ No	Nausea Meds	
		☐ Yes	☐ No	Muscle Relaxers	
		☐ Yes	☐ No	Anxiolytics	

Patient Name:_____ DOB:_____ Assessment Date:_____

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

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

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Family Medical History				
Cancer	☐ Father	☐ Mother	☐ Grandparents	☐ Sibling
Diabetes	☐ Father	☐ Mother	☐ Grandparents	☐ Sibling
Heart Disease	☐ Father	☐ Mother	☐ Grandparents	☐ Sibling
Hypertension	☐ Father	☐ Mother	☐ Grandparents	☐ Sibling
Other: _____	☐ Father	☐ Mother	☐ Grandparents	☐ Sibling

Physical Exam			
Height: Ft:_____ In:_____	Weight: _____ Lbs.	BMI:_____	☐ Unable to Obtain BMI
			Blood Pressure: Sys:_____ Dias:_____
Resp: _____ /Min	Pulse: _____ /Min	O2 Sat: _____	Temp: _____°F

	Within Normal Limits (NL)	Abnormal (AB)	Findings / Specify AB		Within Normal Limits (NL)	Abnormal (AB)	Findings / Specify AB
General Appearance	☐ NL	☐ AB		Lymphatic	☐ NL	☐ AB	
HENT	☐ NL	☐ AB		Musculoskeletal	☐ NL	☐ AB	
Eyes	☐ NL	☐ AB		Skin	☐ NL	☐ AB	
Cardiovascular	☐ NL	☐ AB		Neurological	☐ NL	☐ AB	
Pulmonary	☐ NL	☐ AB		Genitourinary	☐ NL	☐ AB	
Chest/Breast	☐ NL	☐ AB		Other:_____	☐ NL	☐ AB	
Gastrointestinal	☐ NL	☐ AB					

Diagnosis/Assessment		**Treatment Plan**						**Specify/Explain**
1		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other	
2		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other	
3		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other	
4		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other	
5		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other	
6		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other	
7		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other	
8		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other	
9		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other	
10		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other	
11		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other	
12		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other	
13		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other	
14		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other	
15		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other:	
16		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other:	
17		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other:	
18		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other:	
19		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other:	
20		☐ Medication	☐ Monitor	☐ Diet	☐ Labs	☐ Referrals	☐ Other:	

Patient Name:_____ DOB:_____ Assessment Date:_____

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

Patient Name:_____ DOB:_____ Assessment Date:_____

Additional Tests	
☐ Prostate Cancer Screening	Date:
☐ Pap/Pelvic Exam (Age 21 to 65)	Date:
☐ Other: _____	Date:
☐ Results	Date:

Current Vaccinations		
☐ Influenza: Last Date:_____	☐ Series of 3 Hep B vaccinations completed: Date:_____	☐ Tetanus: Last Date:_____
☐ Pneumococcal: ☐ PCV13/Prevnar®: Date:_____	☐ PPSV23/Pneumovax®: Date:_____	
☐ Shingles: ☐ Zostavax®: Date:_____	☐ Shingrix: Date of First Dose: _____	Date of Second Dose: _____

Social History					
☐ Yes	☐ No	Does patient exercise? If yes, how often?_____ Type of Exercise:_____			
☐ Yes	☐ No	Does patient drink alcohol? If yes, how much?_____ Type of Alcohol:_____			
☐ Yes	☐ No	Does patient drink caffeine? If yes, how much?_____			
☐ Yes	☐ No	Does patient currently use tobacco? If yes: # of years used:_____ Type of Tobacco: ☐ Cigarettes ☐ Chew ☐ Pipe ☐ Cigar How often?_____ If no: ☐ Never used or Year Quit:_____			
☐ Yes	☐ No	Does patient use illegal drugs or drugs for which they were not prescribed? If yes: Type:_____ How Used:_____ # of years using:_____			
☐ Yes	☐ No	Does patient use shared needles?	☐ Yes	☐ No	Has patient received a blood transfusion prior to 1985?
☐ Yes	☐ No	Has patient obtained a tattoo?			
☐ Yes	☐ No	If more than one sexual partner, does patient use protection from sexually transmitted infections?			
☐ Yes	☐ No	Does patient wear seatbelt?	☐ Yes	☐ No	Can patient read and/or write?
☐ Yes	☐ No	Does patient live alone?	☐ Yes	☐ No	Does patient have caregiver or family support to assist with ADLs?
☐ Yes	☐ No	Has a vision assessment been completed?	☐ Yes	☐ No	Is patient blind or have severe vision impairment?
☐ Yes	☐ No	Has a hearing assessment been completed?	☐ Yes	☐ No	Does patient have a hearing impairment? If yes, does patient wear a hearing aid? ☐ Yes ☐ 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:	
☐ Assessment of basic activities of daily living (ADLs), such as ☐ bathing, ☐ dressing, ☐ eating, ☐ transferring, ☐ using ☐ toilet, ☐ walking	Date:
☐ Assessment of instrumental ADLs such as ☐ meal preparation, ☐ shopping for groceries, ☐ using public transportation, ☐ housework, ☐ home repair, ☐ laundry, ☐ taking medications or ☐ handling finances	Date:
☐ Results using a standardized functional status assessment tool Name of tool: _____	Date:
☐ Assessment of three of the following four components: ☐ cognitive status; ☐ ambulation status; ☐ sensory ability; ☐ other functional independence, such as ☐ exercise, ☐ ability to perform job	Date:

Fall Risk Assessment			Depression Screening		
☐ Yes	☐ No	Has a fall risk assessment been completed?	☐ Yes	☐ No	Has a depression screening been completed?
If yes, tool used: ☐ STEADI ☐ Morse Fall Risk Assessment ☐ Hendrich Fall Risk Assessment ☐ Other: _____ Results:_____ (Attach results/tool, if available) Date:_____			If yes, tool used: ☐ PHQ-2 ☐ PHQ-9 ☐ Other: _____ Results:_____ 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? ☐ 1-4 days ☐ 5-14 days ☐ 15-30 days ☐ None
In the past 30 days, how many days did physical or mental health interrupt usual activities, such as self-care, work, or recreation? ☐ 1-4 days ☐ 5-14 days ☐ 15-30 days ☐ None

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

Cognitive Assessment			
☐ Yes	☐ No	Has a cognitive assessment been completed?	Date of assessment:_____
If yes, tool used: ☐ Mini-Cog ☐ GPCOG ☐ MIS ☐ 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		
☐	Refer to BlueCross Medical Case Management	Reason: _____

Behavioral Health Case Management		
☐	Refer to BlueCross Behavioral Health Case Management	Reason: _____

Member Stratification Level	☐ Level/Low	☐ 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)