ACO GPRO Preventative Measures

Patient: ____

DOB:

Date Performed: ____/____/____

Please fill out the dates/approximate date and where/who performed.

Mammogram Date:___/___/___ performed at:____________________________

Colonoscopy Date:___/___/___ Procedure:_______________ performed at:____________________________

Tobacco Assessment Date:___/___/___ Never:___Former:___Current User:___Cessation Counselling:___________

Immunizations Flu Vaccination:___/___/___ Pneumonia Vaccination:___/___/___ Type: PCV 13, PPS23
Tdap:___/___/___ Zostavax(shingles):___/___/___ Vaccine refusal date:___/___/___

PHQ-2

Over the ***past two Weeks,*** how often Have you been bothered by any of the following problems?	Not at all	Several days	More then half the days	Nearly Every day
1 Little interest or pleasure in doing things	0	1	2	3
2 Feeling down, depressed, or hopeless	0	1	2	3

Total points:_______________
(if score is higher than 3 points, see PHQ-9)
Past Depression Therapy:________________________
Current Depression Therapy:_____________________

PHQ-9

Over the **past two weeks**, how often have you been bothered by any of the following problems? Soure:http://www.phqscreeners.com/sites/g/files/g10016261/f/201412/PHQ-9	Not At all	Several days	More than half the days	Nearly every day
1 Little interest or pleasure in doing things	0	1	2	3
2 Feeling down, depressed, or hopeless	0	1	2	3
3 Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4 Feeling tired or having little energy	0	1	2	3
5 poor appetite or overeating	0	1	2	3
6 Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7 Trouble concentrating on things, such as reading the newspaper or watching tv	0	1	2	3
8 Moving or speaking so slowly that other people have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9 Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

--PHYSICIAN TO SCORE-- **=Total Score:_________**

M.A. Initials________________ Dr. Initials__________________ Date____/____/____

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ACO GPRO Preventative Measures

Conley Fall Risk

History of falling in the last 3 months? Yes___ No__

Impaired judgement/lack of safety awareness? Yes___ No___

Agitation? Yes___ No___

Impaired gait, shuffle, wide base, unsteady walk? Yes___ No___

Ever experience dizziness or vertigo? Yes___ No___

Ever wet/ soil yourself on the way to the bathroom? Yes___ No___

Focused Functional Assessment

Bathing: ___Independent ___Requires Assistant ___Dependant

Dressing: ___Independent ___Requires Assistant ___Dependant

Toileting: ___Independent ___Requires Assistant ___Dependant

Transferring bed/chair: ___Independent ___Requires Assistant ___Dependant

Continence: ___Independent ___Requires Assistant ___Dependant

Feeding: ___Independent ___Requires Assistant ___Dependant

Are you capable of the following:

Shopping: Yes___ No___

Walking: Yes___ No___

Housekeeping Yes___ No___

Managing own medications: Yes___ No___

Handling finances: Yes___ No___

Advance Care Planning

Do you have an advanced directive? Yes____ No____

If not, are you interested in literature? Yes____ No____

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