Annual Care for Older Adults (COA) Form

absolute total care™

Read Carefully

This form must be completed and signed by the provider. Please save a copy in the patient's medical records.

Patient Name: _____ **DOB:** _____ **ID #:** _____

Date Vitals Collected:_____/_____/_____ **Blood Pressure:**_____/_____

Height: _____ **Weight:** _____ **BMI:**_____

Advance Care Planning (CPT II: 1123F, 1124F, 1157F, 1158F)

Date discussed with Patient/Caregiver: _____/_____/_____

Copy of Advance Care Plan in patient's chart: ☐ **Yes** ☐ **No**

Patient has: ☐ Advance Directives ☐ Surrogate Decision Maker ☐ Living Will ☐ Actionable Medical Orders

Functional Status Assessment (CPT II: 1170F)

Date Assessed: _____/_____/_____ **ADLs Assessed?** ☐ **Yes** ☐ **No** **iADLs Assessed?** ☐ **Yes** ☐ **No**

Was a FSA tool used: ☐ **Yes** ☐ **No** **If YES, name of FSA tool**_____ **Score/Result**_____

Pain Assessment (CPT II: 1125F, 1126F)

Date Assessed:_____/_____/_____ **Does the patient have pain?** ☐ **Yes** ☐ **No**

Medication List and Review (CPT II: 1159F and 1160F)

Attach the member's medication list OR document all prescriptions, over-the-counter and herbal supplements below.

Date:_____/_____/_____ **Medication List attached:** ☐ **Patient not taking any medications:** ☐

Medication/Dosage/Frequency	Medication/Dosage/Frequency

Provider Name (Print): _____

Credentials: ☐ **MD** ☐ **DO** ☐ **NP** ☐ **PA** ☐ **PharmD** ☐ **Other:**_____

Provider Signature: _____ **Date:**_____/_____/_____

If the form is filled out by an office or clinical support staff member, it must route back to the provider for follow-up and sign off.