

1 PATIENT INFORMATION**1 PATIENT DETAILS**

NAME

DOB

AGE / SEX

MRN / PATIENT ID

DATE OF SERVICE

PROVIDER

CREDENTIALS

PRIMARY CARE PROVIDER

VISIT TYPE: CONSULTATION / FOLLOW-UP / ANNUAL WELLNESS VISIT / CHRONIC DISEASE MANAGEMENT / POST-HOSPITAL FOLLOW-UP / TELEHEALTH

CARE SETTING: OUTPATIENT / GERIATRICS CLINIC / PRIMARY CARE / ASSISTED LIVING / SKILLED NURSING FACILITY / HOME VISIT / TELEHEALTH

REFERRAL SOURCE, IF APPLICABLE

INTERPRETER USED, IF APPLICABLE

CAREGIVER / FAMILY MEMBER PRESENT

INFORMANT / COLLATERAL SOURCE

LIVING SITUATION

CC CHIEF COMPLAINT**2 PRIMARY REASON FOR VISIT**

Primary geriatric medicine-related reason for the visit in the patient's or caregiver's own words — chronic disease follow-up, medication review, falls, memory concern, functional decline, weakness, dizziness, weight loss, frailty, post-hospital follow-up, caregiver concern, safety concern, advance care planning, or annual wellness evaluation...

S SUBJECTIVE**3 PATIENT- & CAREGIVER-REPORTED HISTORY****3a PRESENTING CONCERN & INTERVAL HISTORY**

Reason for evaluation (comprehensive geriatric assessment / chronic disease management / post-hospital follow-up / falls

/ cognitive concern / medication review / frailty / functional decline / care coordination / advance care planning / caregiver support):

Interval history (changes since last visit, recent illnesses, emergency visits, hospitalizations, surgeries, specialist visits, new diagnoses, medication changes, functional changes, falls, injuries, change in living situation):

Chronic medical conditions and status (hypertension, diabetes, heart disease, heart failure, atrial fibrillation, COPD/asthma, CKD, dementia, depression, osteoporosis, arthritis, chronic pain, urinary symptoms, sensory impairment):

3b GERIATRIC SYNDROMES

Cognition and memory (memory concerns, confusion, disorientation, word-finding difficulty, missed appointments, medication or financial errors, repetitive questioning, wandering, fluctuations, caregiver observations):

Mood and behavioral health (depression, anxiety, loneliness, grief, irritability, apathy, sleep disturbance, agitation, hallucinations, paranoia, behavioral change, suicidal ideation, caregiver-reported concerns):

Falls and mobility (falls, near falls, gait instability, dizziness, weakness, balance problems, fear of falling, assistive devices, injuries, circumstances of falls, footwear, home hazards, physical therapy):

Functional status — ADLs and IADLs (bathing, dressing, toileting, transferring, feeding, continence, medication management, finances, cooking, shopping, housekeeping, transportation, phone use, supervision needs):

Nutrition and weight (appetite, weight change, diet quality, protein intake, hydration, chewing or swallowing difficulty, dentition, food insecurity, meal preparation ability, supplements, malnutrition risk):

Sleep (duration, insomnia, nighttime awakenings, daytime naps, sleep apnea symptoms, nocturia, restless legs, sleep medications, sleep routine):

Pain (location, severity, duration, functional impact, chronicity, analgesic use, response, side effects, impact on mobility, sleep, mood and ADLs):

Sensory function (hearing loss, vision impairment, glasses or hearing aid use, recent evaluation, communication barriers, impact on function or safety):

Bladder and bowel (urinary frequency, urgency, incontinence, nocturia, retention, constipation, diarrhea, fecal incontinence, bowel regimen, hydration, medication contributors):

3c MEDICATIONS, SUPPORTS & SAFETY

Medication history and polypharmacy (current medications, adherence, missed doses, side effects, high-risk medications, anticholinergic burden, sedatives, benzodiazepines, opioids, anticoagulants, OTC medications, supplements, affordability):

Living situation and supports (lives alone / with family / assisted living / skilled nursing / memory care; caregiver involvement, home health, transportation, meals, social and financial support, care access):

Safety concerns (fall risk, driving safety, medication errors, wandering, stove or fire risk, financial exploitation, elder abuse or neglect, firearm access, unsafe living conditions, need for a higher level of care):

Advance care planning and goals of care (advance directive status, healthcare proxy, code status if discussed, goals of care, treatment preferences, quality-of-life priorities, caregiver understanding):

Pertinent negatives (chest pain, severe dyspnea, syncope, focal neurologic deficit, acute confusion, fever, major fall injury, uncontrolled pain, suicidal ideation, elder abuse or neglect concerns, rapidly worsening function):

ROS GERIATRIC MEDICINE REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Fever, fatigue, appetite change, weight loss, weakness or frailty symptoms	
Chest pain, palpitations, edema, dyspnea, dizziness, presyncope or syncope	
Cough, wheezing, sleep apnea symptoms or oxygen use	
Abdominal pain, constipation, diarrhea, reflux, swallowing difficulty or blood in stool	
Urinary frequency, urgency, incontinence, nocturia, retention or dysuria	

Joint pain, back pain, muscle pain, gait difficulty, falls or mobility limitation

Memory loss, confusion, tremor, weakness, numbness, headache or neurologic symptoms

Depression, anxiety, sleep disturbance, loneliness, behavioral changes or safety concerns

Vision loss, hearing loss, dental concerns or communication barriers

Medication side effects, sedation, dizziness, bleeding/bruising or polypharmacy concerns

O

OBJECTIVE

5

OBSERVED FINDINGS

V

VITALS

TEMPERATURE

BLOOD PRESSURE

HEART RATE

RESPIRATORY RATE

OXYGEN SATURATION

HEIGHT

WEIGHT

BMI

PAIN SCORE, IF APPLICABLE

ORTHOSTATIC VITALS, IF OBTAINED

General appearance (alertness, distress, frailty, nutritional appearance, hygiene, mobility, assistive device use, interaction with caregiver, overall condition):

HEENT (conjunctiva, sclera, pupils, extraocular movements, hearing ability, hearing and vision aids, oral mucosa, dentition, hydration status, swallowing-related findings):

Neck (range of motion, lymphadenopathy, thyroid findings, carotid bruits, masses, tenderness, jugular venous distention):

Cardiovascular (rate, rhythm, murmurs, rubs, gallops, pulses, capillary refill, edema, perfusion, signs of volume overload or dehydration):

Pulmonary (respiratory effort, breath sounds, wheezes, crackles, rhonchi, cough, oxygen requirement, work of breathing):

Abdomen (bowel sounds, tenderness, distension, guarding, rebound, masses, hepatosplenomegaly, hernia, surgical scars):

Musculoskeletal (range of motion, joint tenderness, swelling, deformity, strength, muscle wasting, gait, balance, transfers, posture, mobility limitations):

Neurologic (mental status, orientation, strength, sensation, reflexes, coordination, gait, tremor, focal deficits, neuropathy, cognitive screening findings):

Skin (bruising, wounds, pressure injuries, rashes, ulcers, edema, skin tears, dryness, color changes, infection signs, signs of poor hygiene or self-care):

Psychiatric (mood, affect, behavior, speech, thought process, insight, judgment, cognition, cooperation, safety concerns):

CG

COMPREHENSIVE GERIATRIC ASSESSMENT

6

DOMAINS ASSESSED

COGNITION AND MEMORY	MOOD AND BEHAVIORAL HEALTH
MOBILITY, GAIT, BALANCE & FALL RISK	ADLS AND IADLS
NUTRITION AND WEIGHT STATUS	VISION, HEARING AND DENTAL STATUS
CONTINENCE AND BOWEL FUNCTION	PAIN AND SLEEP
MEDICATION BURDEN & HIGH-RISK MEDICATIONS	SOCIAL SUPPORT AND CAREGIVER NEEDS
HOME SAFETY AND LIVING ENVIRONMENT	ADVANCE CARE PLANNING AND GOALS OF CARE
NEED FOR THERAPY, HOME HEALTH, COMMUNITY RESOURCES OR A HIGHER LEVEL OF CARE	

ST

SCREENING / ASSESSMENT TOOLS

7

SCORES, INTERPRETATION, INFORMANT SOURCE & LIMITATIONS

MINI-COG	MOCA
MMSE	PHQ-2 / PHQ-9
GAD-7	GERIATRIC DEPRESSION SCALE

TIMED UP AND GO

FALL RISK SCREENING

FRAILITY SCALE

ADL / IADL ASSESSMENT

NUTRITIONAL SCREENING TOOL

PAIN SCALE

STOP-BANG / SLEEP APNEA SCREENING

SOCIAL DETERMINANTS OF HEALTH SCREENING

ELDER ABUSE / NEGLECT SCREENING

MR

MEDICATION REVIEW / DEPREScribing ASSESSMENT

8 MEDICATION SAFETY REVIEW

MEDICATION RECONCILIATION COMPLETED

TOTAL NUMBER OF MEDICATIONS

HIGH-RISK MEDICATIONS IDENTIFIED

SEDATING MEDICATIONS

ANTICHOLINERGIC BURDEN

BENZODIAZEPINES / OPIOIDS / SLEEP AIDS / MUSCLE RELAXANTS

ANTICOAGULANT OR ANTIPLATELET USE & BLEEDING RISK

RENAL OR HEPATIC DOSE CONCERNS

MEDICATION INTERACTIONS

DUPLICATE THERAPIES

ADHERENCE BARRIERS

PILLBOX, CAREGIVER, PHARMACY OR BLISTER-PACK SUPPORT

Deprescribing opportunities and shared decision-making:

Refills, monitoring and follow-up needs:

L

LABORATORY AND DIAGNOSTIC RESULTS

9 REVIEWED OR ORDERED

Routine labs (CBC, CMP, renal and liver function, electrolytes, glucose, HbA1c, lipid panel, TSH, urinalysis, urine albumin-creatinine ratio, vitamin D, B12, folate, iron studies, nutrition markers):

Medication monitoring (INR, drug levels, renal dosing labs, hepatic monitoring, sodium, potassium, magnesium):

Cognitive / reversible cause workup (B12, TSH, folate, RPR, HIV if indicated and consented, urinalysis, infection workup,

sleep study, neuroimaging, neuropsychological testing):

Falls and bone health testing (DEXA, vitamin D, calcium, orthostatic vitals, EKG, gait assessment, fracture imaging, osteoporosis labs):

Imaging and diagnostic testing (X-ray, CT, MRI, ultrasound, echocardiogram, EKG, Holter, pulmonary testing, sleep study):

Preventive screening results (cancer screening, vision and hearing testing, dental evaluation, osteoporosis screening, immunization records):

Prior records reviewed (hospital records, discharge summaries, specialist notes, medication history, home health and therapy notes, facility records, caregiver reports, lab trends, imaging reports, advance care planning documents):

A

ASSESSMENT

10 GERIATRIC MEDICINE CLINICAL INTERPRETATION

Primary diagnosis or working diagnosis. Chronic condition status. Functional status and level of independence. Cognitive status and safety implications. Frailty, fall risk, mobility limitations and injury risk. Medication burden, high-risk medications, adverse effects and deprescribing opportunities. Nutritional status and weight trend. Pain, sleep, mood, continence, sensory or caregiver-related concerns. Social determinants, caregiver support, home safety and living situation. Preventive care gaps. Advance care planning or goals-of-care needs. Need for labs, imaging, medication changes, referrals, therapy, home health, social work, care coordination, a higher level of care or urgent evaluation...

P

PLAN

11 GERIATRIC MEDICINE MANAGEMENT BY PROBLEM

Chronic disease management. Medication optimization (reconciliation, dose adjustment, deprescribing, high-risk medication reduction, adherence support, refills, side effect monitoring, pharmacy coordination). Falls and mobility plan (physical therapy, assistive devices, footwear, home safety, orthostatic evaluation, vision and hearing correction, bone health, fall-prevention counseling). Cognitive plan (screening, reversible cause workup, caregiver education, safety planning, driving, financial and medication management review, referral, monitoring). Functional support plan (ADL/IADL assistance, home health, occupational therapy, caregiver support, community resources, transportation, meals, higher

level of care). Nutrition plan. Mood and sleep plan. Pain plan. Continence and bowel plan. Preventive care plan. Safety and elder protection plan. Advance care planning. Referral and care coordination. Patient and caregiver education...

F

FOLLOW-UP

12 REASSESSMENT PLAN

Follow-up timeframe and purpose (chronic disease monitoring, medication review, fall risk reassessment, cognitive monitoring, lab or imaging review, functional status review, caregiver support, preventive care completion, advance care planning follow-up, urgent return precautions):

TB

TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

CAREGIVER / FAMILY COUNSELING TIME

MEDICATION REVIEW / DEPRESCRIBING TIME

CARE COORDINATION TIME

RECORDS REVIEW TIME

ADVANCE CARE PLANNING TIME

E/M LEVEL: 99202 / 99203 / 99204 / 99205 / 99212 / 99213 / 99214 / 99215

ANNUAL WELLNESS VISIT CODE, IF APPLICABLE

ADVANCE CARE PLANNING CODE(S)

TRANSITIONAL CARE MANAGEMENT CODE(S)

CHRONIC CARE MANAGEMENT CODE(S)

COGNITIVE ASSESSMENT / CARE PLANNING CODE(S)

BASIS FOR BILLING: TIME-BASED / MEDICAL DECISION MAKING / PREVENTIVE CARE / ADVANCE CARE PLANNING / TRANSITIONAL CARE / CARE COORDINATION

PRIMARY ICD-10 CODE

SECONDARY ICD-10 CODE(S)

SO

PROVIDER SIGN-OFF

PROVIDER NAME

CREDENTIALS

SPECIALTY: GERIATRIC
MEDICINE

DATE

TIME
