Senior Whole Health
A MAGELLAN COMPANY

PCP Clinical Assessment

Instructions: Please complete the following assessment or similar electronic health summary for your Senior Whole Health of New York member. PCP signature is required. Fax completed form to SWH of NY at 1-855-818-4871.

<table>
<tr><td>Member Last Name</td><td>Member First Name</td><td>DOB</td></tr>
<tr><td>Member ID #</td><td>Allergies</td><td rowspan="2">Immunizations Date
Flu Vx ☐__/ __/___
Pneumo ☐__/ __/___
Zoster ☐__/ __/___
Tetanus ☐__/ __/___</td></tr>
<tr><td>Health Care Proxy? Yes ☒ No ☐
Name and Contact Information</td><td>Advance Directive?
Yes ☒ No ☐

Date:____/____/____</td></tr>
<tr><td>Guardian? Yes ☐ No ☐
Name and Contact Information</td><td>Height: ____ feet ___ inches
Weight: _____
BMI: _____
Date Taken: ____/_____/_____</td><td>Pertinent Labs</td></tr>
<tr><td colspan="3">List Medical Diagnoses</td></tr>
<tr><td colspan="3">Diabetes: Yes ☐ No ☐
If “yes,” Last HbA1c Result:_____Date:_____/____/____</td></tr>
<tr><td colspan="3">Hypertension: Yes ☐ No ☐
If “yes,” Date Diagnosed:_____/____/____Most Recent BP:_____/_____Date:_____/____/____</td></tr>
<tr><td colspan="3">Cancer Screenings:
Most recent Mammogram (if applicable): ____/____/____ Result: _____
Colorectal Cancer Screening:
Colonoscopy: Date:____/____/_____Result: _____
Flex Sig: Date:____/____/_____Result: _____
FOBT: Date:____/____/_____Result: _____</td></tr>
<tr><td colspan="3">Other Medical or Behavioral Health Diagnoses</td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td colspan="2"></td><td></td></tr>
</table>

Medications: If more than five medications, please attach a list to this form.
Please have PCP sign attached list.

Medication Name	Dose	Start Date (if known)	End Date (if known)

Functional Status: ☐ Self Care ☐ Minimal Support ☐ Moderate Support ☐ Maximal Assist

Last ADL Screening Date: __/___/_____ Last IADL Screening: ____/__/___
Last Pain Screening: _____/___/____

What was last hospitalization date? (if known)

What is the member's risk for hospitalization in the next 90 days (1 is low risk – 5 is high risk)
1☐ 2☐ 3☐ 4☐ 5☐

What are some things you believe the member may need help with?

Medication Adherence ☐ Nutrition Counseling ☐
Keeping Specialty Appointments ☐ Biometric Monitoring ☐
Other: ☐

Please contact Senior Whole Health of New York Member Services at 1-877-353-0185 with further concerns.

PCP Signature:_____ **Date Signed:**_____/_____/_____