Annual Care for Older Adults (COA) Form

Read Carefully

This form must be reviewed and signed by the physician or other provider. Please save a copy in the patient's medical records. This form is available in the Provider Library on Health Net's provider portal at provider.healthnetcalifornia.com > Provider Library under Forms and References, or go directly to providerlibrary.healthnetcalifornia.com.

Patient Name: ______________________ DOB: _____ /_____ /______ ID #: __________________

Date Vitals Collected: ______ /_____ /______ Blood Pressure: __________ /__________

Functional Status Assessment (CPT II: 1170F)

Date Assessed: ___ /___ /___ ADLs Assessed? ☐ Yes ☐ No IADLs Assessed? ☐ Yes ☐ No

Was an 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.

This section must be reviewed and signed by prescribing provider or clinical pharmacist.

Date Reviewed: _____ /_____ /______ 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.

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Advance Care Planning (ACP) Form

Read Carefully

This form must be reviewed and signed by the physician or other provider. Please save a copy in the patient's medical records. This form is available in the Provider Library on Health Net's provider portal at provider.healthnetcalifornia.com > Provider Library under Forms and References, or go directly to providerlibrary.healthnetcalifornia.com.

Patient Name: ________________ DOB: _____ /_____ / ______ ID #: ____________

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

Provider Name (Print): ____

Credentials: ☐ MD ☐ DO ☐ NP ☐ PA ☐ PharmD ☐ Other: ___________________________

Provider Signature: ________________________________Date: _____ /_____ /______

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