

# Annual Care for Older Adults (COA) Form

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## 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.

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