evolution
REHAB GROUP

SCREENING DATA FOR CMS vs 2020

Please complete at each new Certification period and any Re-Certifications.
To the provider performing the screening, **please let the office know** if the **patient answers any** of the items marked in **bold and underline** so that their physician can help in this matter. Ask the questions out loud to the patient or their caregiver who is authorized to answer on their behalf and note the answers below.

Patient Name:____ DOB:________________

1. Please answer the following question regarding Tobacco/Nicotine use
   Do you use any of these products at least once a week (check all that apply)
   ❑ Cigarettes ❑ Cigars ❑ Pipe
   ❑ E-cigarettes/Vape ❑ Hookah/Water Pipes ❑ Chewing Tobacco
   If you checked any above, would you be interested in a Nicotine/Tobacco/smoking cessation assistance provided by your physician practice? **❑ Yes** ❑ No
2. If any of the episode of care falls between 10/1 and 3/31 please answer the following regarding Influenza Vaccination, if not, then skip to question 3
   Did you receive the influenza vaccine for this year's flu season?
   ❑ Yes- from my PCP ❑ Yes- at a hospital stay ❑ Yes-from the pharmacy
   ❑ Yes- from my community (ALF, ILF, religious organization, neighborhood drive)
   ❑ Yes- from another provider ❑ Yes- from one of my physicians who is not my PCP ❑ Yes- during a SNF stay
   ❑ No- I decline to have it ❑ **No-but I would like it** ❑ No, I am not allowed to have it
   ❑ No- there wasn't any available ❑ No, other reason
3. Pneumococcal Vaccine- Have you ever received the Pneumococcal Vaccine (to prevent pneumonia)?
   ❑ Yes- from my PCP ❑ Yes- at a hospital stay ❑ Yes-from the pharmacy
   ❑ Yes- from my community (ALF, ILF, religious organization, neighborhood drive)
   ❑ Yes- from another provider ❑ Yes- from one of my physicians who is not my PCP ❑ Yes- during a SNF stay
   ❑ No- I decline to have it ❑ **No-but I would like it** ❑ No, I am not allowed to have it
   ❑ No- there wasn't any available ❑ No, other reason
4. Depression Screen with PHQ-2 ©
   If the total below > 2 then please let the office know so they can let the physician know

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	❑ 0	❑ 1	❑ 2	❑ 3
Feeling down, depressed or hopeless	❑ 0	❑ 1	❑ 2	❑ 3

5. Please use the MAHC-10 fall screening on next page and then answer below
   If the patient was screened to be at high fall risk (>3 points) how did you help mitigate any falls
   ❑ I included fall prevention into the current therapy plan of care
   ❑ I have recommended proper precautions to help mitigate fall risks
   ❑ I have recommended proper devices to help mitigate fall risks

Provider Name:________________________________ Date:______________________

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MAHC 10 -Fall Risk Assessment Tool

Patient Name	DOB	DATE
Age 65+		❑ Yes- 1 point
Diagnosis (3 or more co-existing) Includes only documented medical diagnosis		❑ Yes- 1 point
Prior history of falls within 3 months An unintentional change in position resulting in coming to rest on the ground or at a lower level		❑ Yes- 1 point
Incontinence Inability to make it to the bathroom or commode in timely manner Includes frequency, urgency, and/or nocturia.		❑ Yes- 1 point
Visual impairment Includes but not limited to, macular degeneration, diabetic retinopathies, visual field loss, age related changes, decline in visual acuity, accommodation, glare tolerance, depth perception, and night vision or not wearing prescribed glasses or having the correct prescription.		❑ Yes- 1 point
Impaired functional mobility May include patients who need help with IADLS or ADLS or have gait or transfer problems, arthritis, pain, fear of falling, foot problems, impaired sensation, impaired coordination or improper use of assistive devices.		❑ Yes- 1 point
Environmental hazards May include but not limited to, poor illumination, equipment tubing, inappropriate footwear, pets, hard to reach items, floor surfaces that are uneven or cluttered, or outdoor entry and exits.		❑ Yes- 1 point
Poly Pharmacy (4 or more prescriptions – any type) *All PRESCRIPTIONS including prescriptions for OTC meds.* Drugs highly associated with fall risk include but not limited to, sedatives, anti-depressants, tranquilizers, narcotics, antihypertensives, cardiac meds, corticosteroids, anti-anxiety drugs, anticholinergic drugs, and hypoglycemic drugs.		❑ Yes- 1 point
Pain affecting level of function Pain often affects an individual's desire or ability to move or pain can be a factor in depression or compliance with safety recommendations		❑ Yes- 1 point
Cognitive impairment Could include patients with dementia, Alzheimer's or stroke patients or patients who are confused, use poor judgment, have decreased comprehension, impulsivity, memory deficits. Consider patients ability to adhere to the plan of care		❑ Yes- 1 point
TOTAL SCORE		