Comprehensive Annual Visit (CAV) Form

Patient Name: ______________________ **Date of Service:** ___/___/___

ATRIO Member ID: ______________ **Date of Birth:** ___/___/___ **Gender:** ☐ Male ☐ Female

Medical History

If marked as "active", please also document condition in "Diagnosis" section

Condition	Description/Remarks	Active	Resolved
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

Surgical History

Procedure	Reason for Procedure	Date

Current Medications

Include prescriptions, over-the-counter medications and supplements

☐ Medication review and reconciliation performed

Name of Medication	Dose/Frequency	Condition(s) Being Treated

Medical Allergies

____

____

____

Social History

Alcohol/drug use: ______________ High-risk lifestyle: ______________

Tobacco use: ______________ Physical activity: ______________

Patient Name: ______________________ **Date of Service:** ____/____/____

ATRIO Member ID: ______________ **Date of Birth:** ____/____/____

Vitals

Height: ______Feet ______Inches **Weight:** ______pounds **Body Mass Index (BMI):** ________

Blood Pressure: ____/____ **Heart Rate:** ________

Physical Examination

	Within Normal Limits	Abnormal	Findings
General appearance	☐	☐	
HEENT	☐	☐	
Cardiovascular	☐	☐	
Respiratory	☐	☐	
Gastrointestinal	☐	☐	
Hematologic/lymph	☐	☐	
Musculoskeletal	☐	☐	
Skin	☐	☐	
Neurological	☐	☐	
Genitourinary	☐	☐	
Other	☐	☐	

Additional Comments

____

____

Breast Cancer Screening: Women ages 52-74 years old

Order if no screening performed within the last 2 years or report mastectomy if appropriate

☐ Not applicable due to age or gender ☐ Mammogram order placed Last mammogram: ____/____/____

☐ Not applicable due to mastectomy

Colorectal Cancer Screening: Members 50-75 years old

Order if no screening performed within timeframe indicated below **Date of Screening**

☐ Order placed

☐ Not applicable due to:

- ☐ Age
- ☐ Colorectal cancer
- ☐ Total colectomy

☐ Fecal occult blood test (FOBT) (1 year)

☐ FIT-DNA test (2 years)

☐ CT colonography (4 years) ____/____/____

☐ Flexible sigmoidoscopy (4 years)

☐ Colonoscopy (9 years)

Diabetic Care – Nephropathy: Members 18-75 years old diagnosed with diabetes mellitus

		Date of Lab	Result
☐ Not applicable: no diabetes diagnosis	☐ Microalbumin test	____/____/____	________
☐ Urine protein lab order placed	☐ Macroalbumin test	____/____/____	________

☐ ACE/ARB therapy – Medication name: ______________________

☐ Referred to Nephrologist – name: ______________________

Patient Name: ______________________ **Date of Service:** ____/____/____

ATRIO Member ID: ______________ **Date of Birth:** ____/____/____

Diabetic Care – Eye Care: Members 18-75 years old diagnosed with diabetes mellitus

	Retinopathy Screening	Eye Exam Date	Eye Care Professional
☐ Not applicable: no diabetes diagnosis	☐ Positive	____/____/____	______________
☐ Referred for dilated retinal eye exam	☐ Negative		

Diabetic Care – HbA1c: Members 18-75 years old diagnosed with diabetes mellitus

	Date of HbA1c Lab	Test Result
☐ Not applicable: no diabetes diagnosis	____/____/____	______________
☐ HbA1c lab ordered		

Pain Screening: Members 66 years and older

Circle the level of pain patient is in on a daily basis	Comments
☐ Not applicable due to age	
☺ 0 1 2 3 4 5 6 7 8 9 10 ☹	
No pain Moderate pain Severe pain	

Functional Status Assessment: Members 66 years and older

☐ Not applicable due to age

ABILITY TO USE TELEPHONE		SHOPPING	
1. Operates telephone on own initiative	1	1. Takes care of all shopping needs independently	1
2. Dials a few well-known numbers	1	2. Shops independently for small purchases	0
3. Answers telephone but does not dial	1	3. Needs to be accompanied on any shopping trip	0
4. Does not use telephone at all	0	4. Completely unable to shop	0
HOUSEKEEPING		**MODE OF TRANSPORTATION**	
1. Maintains house alone or with occasional assistance	1	1. Travels independently on public transportation or drives own car	1
2. Performs light daily tasks such as dish washing or bed making	1	2. Arranges own travel via taxi but no other modes of transportation	1
3. Performs light daily tasks - can't maintain acceptable level of cleanliness	1	3. Travels on public transportation when accompanied by another	1
4. Needs help with all housekeeping tasks	1	4. Travel limited to full assistance by another	0
5. Does not participate in any housekeeping tasks	0	5. Does not travel at all	0
LAUNDRY		**RESPONSIBILITY FOR MEDICATIONS**	
1. Does personal laundry completely	1	1. Is able to take medications in correct dosages at correct time	1
2. Launders small items	1	2. Takes medications if they are prepared in advance in correct dosages	0
3. All laundry must be done by others	0	3. Is not capable of dispensing own medications	0
FOOD PREPARATION		**ABILITY TO HANDLE FINANCES**	
1. Plans, prepares and serves adequate meals independently	1	1. Manages financial matters independently (e.g., pay bills, go to the bank)	1
2. Prepares adequate meals if supplied with ingredients	0	2. Manages day-to-day matters, needs help with banking, major purchases	1
3. Prepares meals but does not maintain adequate diet	0	3. Incapable of handling money	0
4. Needs to have meals prepared and served	0		

TOTAL SCORE: __________

Total score ranges from 0 (very dependent) and 8 (totally independent)

Advanced Care Planning: Members 66 years and older

☐ Discussed; plan or surrogate decision maker documented in the medical record

☐ Discussed; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

☐ Not applicable due to age

Patient Name: ______________________ **Date of Service:** ___/___/___

ATRIO Member ID: ______________ **Date of Birth:** ___/___/___

Diagnoses - Provide the appropriate *active* and chronic conditions

	Diagnosis	ICD-10 Code	Condition Status	Treatment Plan *(select for each diagnosis)*
1.				Medication / Monitor / Diet / Labs / Referral / Other
2.				Medication / Monitor / Diet / Labs / Referral / Other
3.				Medication / Monitor / Diet / Labs / Referral / Other
4.				Medication / Monitor / Diet / Labs / Referral / Other
5.				Medication / Monitor / Diet / Labs / Referral / Other
6.				Medication / Monitor / Diet / Labs / Referral / Other
7.				Medication / Monitor / Diet / Labs / Referral / Other
8.				Medication / Monitor / Diet / Labs / Referral / Other
9.				Medication / Monitor / Diet / Labs / Referral / Other
10.				Medication / Monitor / Diet / Labs / Referral / Other
11.				Medication / Monitor / Diet / Labs / Referral / Other
12.				Medication / Monitor / Diet / Labs / Referral / Other
13.				Medication / Monitor / Diet / Labs / Referral / Other
14.				Medication / Monitor / Diet / Labs / Referral / Other
15.				Medication / Monitor / Diet / Labs / Referral / Other
16.				Medication / Monitor / Diet / Labs / Referral / Other
17.				Medication / Monitor / Diet / Labs / Referral / Other
18.				Medication / Monitor / Diet / Labs / Referral / Other
19.				Medication / Monitor / Diet / Labs / Referral / Other
20.				Medication / Monitor / Diet / Labs / Referral / Other

Assessment Statement

By signing this document, you attest to having assessed the patient in a face-to-face visit and reviewed the medical documents to complete the form using the best of your medical knowledge, having placed the completed original of this form in the patient's medical record and having ensured fully documented proof of service of all completed fields is contained in the patient's medical record. If the practice has an electronic medical record system, scan the assessment and attach the image to the electronic record. To the best of my knowledge, information and belief, the information provided regarding diagnoses is truthful and accurate.

______________________________ ____________

Provider name and credentials (printed) Date

Compensation Payable To: ______________________ Office Phone: ( ) -

Provider ID: ______________ ID Type: ☐ TIN Office Fax: ( ) -

Mailing Address: ______________________ City, State, ZIP: ______________

Office Manager Name: ______________________ Email: ______________

Submit copy of form and chart note to **ATRIO Health Plans**:
CAV Team Fax: **(866) 255-1032** or Email: **CAV@atriohp.com** Secure email only
Email Questions To: QI@atriohp.com