Improving Care for Older Adults: HEDIS® COA Form

Pre-collection of the following patient information meets the needs of your patient and satisfies your practice's HEDIS requirements.

Member Name	Member ID	Member DOB	Date of Service
		___/___/_____	___/___/_____
PCP Name	**Provider ID**	**Provider Phone No.**	

Functional Assessment - Activities of Daily Living (CPT coding 1170F)

Completely Independent: ☐ Y / ☐ N (if No, check type of assistance required below)

Assistance with ADLs:

☐ Bathing	☐ Dressing	☐ Eating
☐ Transferring	☐ Toileting	☐ Walking

Assistance with IADLs:

☐ Shopping	☐ Driving OR Using Public Transportation	☐ Using the Phone
☐ Meal Preparation	☐ Housework	☐ Home Repair
☐ Laundry	☐ Taking Medications	☐ Handling Finances

Has Caregiver in Place: ☐ Y / ☐ N

HHA Service hours per week: __________

Notes:

CM Referral:

FSA Completed by ____ Date ___/___/_____

Pain Assessment: 1125F (pain noted) / 1126F (no pain noted)

Does the member have pain? ☐ Y / ☐ N

On a scale from 0 to 10 (10 being max pain) what is the intensity of pain prior to treatment?

NO PAIN | MILD | MODERATE | SEVERE | WORST

0 1 2 3 4 5 6 7 8 9 10

Result:

Notes:

PSA Completed by ____ Date ___/___/_____

Medication Review: 1159F (med list) AND 1160F (meds reviewed)						
Pharmacy Name:			Pharmacy Phone:			
Medication	Dose	Route	Frequency	Use	New?	Last Filled
					☐ Y / ☐ N	__/__/___
					☐ Y / ☐ N	__/__/___
					☐ Y / ☐ N	__/__/___
					☐ Y / ☐ N	__/__/___
					☐ Y / ☐ N	__/__/___
					☐ Y / ☐ N	__/__/___
					☐ Y / ☐ N	__/__/___
					☐ Y / ☐ N	__/__/___
					☐ Y / ☐ N	__/__/___
					☐ Y / ☐ N	__/__/___
					☐ Y / ☐ N	__/__/___
					☐ Y / ☐ N	__/__/___
Over the counter medications (use of anti-inflamatory or analgesic medications for symptom relief)						
					☐ Y / ☐ N	__/__/___
					☐ Y / ☐ N	__/__/___
					☐ Y / ☐ N	__/__/___
					☐ Y / ☐ N	__/__/___
Did the member fill meds under health plan? ☐ Y / ☐ N If no, explain:						
Pharmacist's Signature ______________________________						
Medications were reviewed with the patient / primary caregiver and list is updated as of ___/___/_____						

Primary Care Physician's Name (print)
Credentials: ☐ MD / ☐ DO / ☐ NP / ☐ PA

Primary Care Physician's Signature