CARE FOR OLDER ADULT ASSESSMENT (COA)

THIS FORM IS REQUIRED BY INSURANCE COMPANIES ONCE A YEAR, IF YOU ARE OVER THE AGE OF 65
Please fill out the following question to the best of your knowledge

_____ _____ _____
Patient Name DOB Today's Date

Height: _____ Weight: _____ Blood Pressure: _____ /_____ Smoker: ☐ Y ☐ N

Last mammogram: _____/_____ Last colonoscopy: _____/_____ Last Influenza vaccine: _____/_____

Medication Review/List: (**SEE PATIENT'S CHART)**

PHYSICAL FUNCTIONS

Please mark all the physical functions that apply in the following categories:

Hearing: ☐ Excellent ☐ Good ☐ Poor ☐ Deaf ☐ Hearing Aids

Speech: ☐ Excellent ☐ Good ☐ Poor ☐ Post-Stroke ☐ Stutter ☐ Mute ☐ Slurred

Mobility: ☐ Excellent ☐ Good ☐ Fair ☐ Relies on Others ☐ Cane/Walker ☐ Chair/Scooter

Touch: ☐ Intact ☐ Decreased Sensitivity (Hot/Cold) ☐ Numbness

Vision: ☐ Excellent ☐ Good ☐ Poor ☐ Glasses ☐ Contacts ☐ Glaucoma

☐ Diabetic Retinopathy ☐ Macular Degeneration

Smell/Taste: ☐ No Problems ☐ Some Changes

ACTIVITIES OF DAILY LIVING

Please mark any of the following daily living activities that you require help with:

☐ Grooming ☐ Dressing ☐ Toilet Use ☐ Housework ☐ Shopping

☐ Eating ☐ Walking ☐ Bathing ☐ Driving ☐ Finances

☐ Preparing Meals ☐ Transferring From Sitting to Standing

SOCIAL SUPPORT

Please mark any of the following social support types that you have:

☐ Have a Supportive Family ☐ Have Supportive Friends ☐ Participate in Clubs, Church or Groups

ADVANCED DIRECTIVES

Please mark any of the following advanced directives that you:

☐ Living Will ☐ Durable Power of Attorney ☐ Five Wishes ☐ DNR

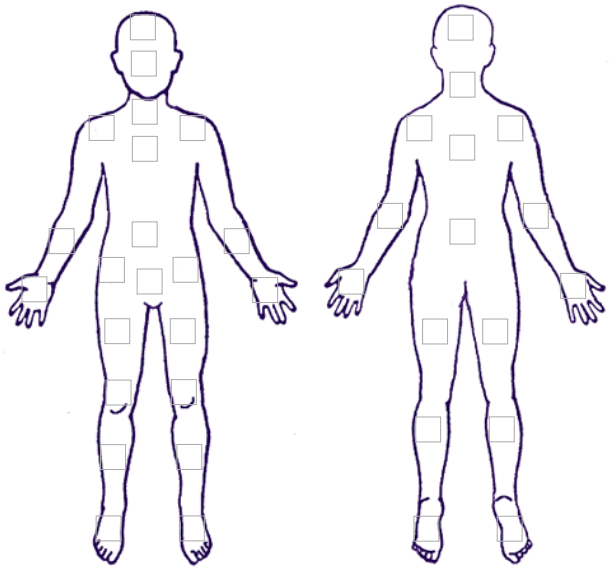
Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At All	Several Days	More Than Half The Days	Nearly Every Day
1.) Little interest or pleasure in doing things				
2.) Feeling down, depressed or helpless				

CHRONIC PAIN

Have you fallen in the last year? ☐ YES ☐ NO

Do you have any chronic pain? ☐ YES ☐ NO

* If **YES**, circle the area(s) of this pain on the diagram below:



Please describe the pain:

- ☐ Aching
- ☐ Crushing
- ☐ Sharp
- ☐ Stabbing
- ☐ Throbbing
- ☐ Burning
- ☐ Tingling
- ☐ Cramping

Also rate the pain using the pain scale to the left:

** PROVIDER SECTION **

Medication reviewed? ☐ YES ☐ NO **Under Pain Management?** ☐ YES ☐ NO

Advanced Directives Discussed? ☐ YES ☐ NO **Member/Family Education Provided?** ☐ YES ☐ NO

Cognitive Status: ☐ EXCELLENT ☐ DIMINISHEDD ☐ DEMENTIA ☐ ALZHEMER'S ☐ PARKINSON

_____ _____

Provider Signature Date