

Annual Care for Older Adults (COA) Form



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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