Middlesex Health Primary Care

Dear Patient,

We hope this letter finds you in good health! We look forward to your upcoming Wellness Visit. This packet includes a Wellness Assessment Form, Patient Health Questionnaire, and information on advance care planning. Please **complete** the **Wellness Assessment Form and Patient Health Questionnaire** via MyChart eCheck-in before your visit at https://middlesexhealth.org/MyChart.

(If you're unable to access it online, then please bring the completed paper form to your visit).

As a reminder, Wellness Visits are offered yearly to patients with Medicare insurance. The main focus is on preventive care to help identify health risks and work together on ways to reduce them.

At your upcoming visit, your provider will take a complete health history and perform the following:

- Screenings to detect depression, fall risk, memory impairment and other health problems
- Counseling on nutrition, physical activity and advance care planning
- Creation of a personalized wellness and prevention plan
- A limited physical exam to check blood pressure, height, weight and other measures based on your health history *(This visit does not typically include a traditional head-to-toe physical)*

Our primary care team is committed to managing your health and we thank you for being a patient at Middlesex Health Primary Care. Please feel free to contact us with any questions or concerns prior to this appointment.

Sincerely,

Middlesex Health Primary Care

Please note that a wellness visit is not intended to address acute problems or new concerns. If you wish to discuss other health issues, please inform your provider. A separate appointment may be needed to address these concerns, or, if they are able to be discussed at the wellness visit, a separate charge may apply for these services.

Middlesex Health Primary Care

RECOGNIZED NCQA PATIENT-CENTERED MEDICAL HOME

Introduction to Advance Care Planning

What is Advance Care Planning?
Making plans now for the care you want when you have a serious illness or when you may become unable to make your own decisions or speak for yourself is often called "Advance Care Planning."

It involves learning about your illness, understanding treatment options, wishes and preferences for the type of care you wish to receive as well as how to appoint someone to make decisions on your behalf.

How to go about Advance Care Planning?
Working to create an Advance Directive with the help of family, legal services, your physician and other healthcare providers can outline your wishes.

What is an Advance Directive?
An Advance Directive is a legal document in which you may provide directions or express your preferences about medical care and/or to appoint someone to act on your behalf.

Advance Directives are used when you are unable to make or communicate decisions about your medical treatment.

It is recommended that they be prepared before any condition or event occurs that causes you to be unable to actively make a decision about your medical care.

In Connecticut, they include the living will or health care instructions and the appointment of a health care representative.

Preparing for the future
If you already have an Advance Directive, make sure to share a copy with your healthcare provider and the person you have named as your health care representative.

If you do not have one, please discuss this further with your provider at your upcoming Wellness Visit.

Additional helpful resources:
Excellent 2 minute video - https://www.mayoclinic.org/patient-education/?VID=VID-20101390
Free State of CT living will - https://portal.ct.gov/AG/Health-Issues/Connecticuts-Living-Will-Laws

MIDDLESEX HEALTH PRIMARY CARE –*Wellness Assessment Form*

Name: _____ DOB: _____ Date: _____

1. In the past year, have you had any new medical diagnoses or surgical procedures?

◯ No ◯ Yes *Please explain*:_____
_____

2. In the past year, have you been hospitalized, seen in the emergency room, or stayed in a nursing home?

◯ No ◯ Yes *Please explain*: _____
_____

3. List additional health care providers involved in your care? *Please list name and specialty.*

_____
_____
_____

4. Are you currently working?

◯ No ◯ Yes *Occupation:* _____

5. In a typical day and week, how many alcoholic beverages do you consume? *(e.g. beer or wine)*

Number of drinks/day: _____
Number of drinks/week: _____

6. Do you smoke?

◯ Never ◯ Former Smoker ◯ Current smoker

7. How would you describe your diet?

◯ Diabetic
◯ Heart Healthy
◯ "Meat & Potatoes"
◯ Mediterranean
◯ Vegetarian
◯ Other: _____

8. Do you exercise regularly? *(At least 30 minutes 3 times a week)*

◯ No ◯ Yes

9. Have you fallen in the past year?

◯ No ◯ Yes

10. How often do you feel unsteady, dizzy or are afraid of falling?

◯ Never
◯ Seldom
◯ Sometimes
◯ Often
◯ Always

11. Who do you live with?

◯ Alone
◯ Spouse / Significant other
◯ Family
◯ Assisted Living
◯ Nursing Home
◯ Other: _____

12. Do you plan on changing your current living arrangement in the next year?

◯ No ◯ Yes *Please explain:* _____

13. Do you have any home safety concerns? *(such as poor lighting or loose rugs)*

◯ No ◯ Yes *Please explain*: _____

14. In a typical week, how often do you forget to take your medications?

◯ Never
◯ Seldom
◯ Sometimes
◯ Often
◯ Always

15. Do you think that any of your pills are making you sick?

◯ No ◯ Yes ◯ Maybe

16. During the past four weeks, have you felt anxious, depressed, irritable, sad, or blue?

◯ No ◯ Yes

17. Does your physical or emotional health limit your social activities with family and/or friends?

◯ Never
◯ Seldom
◯ Sometimes
◯ Often
◯ Always

18. Do you, or others, have concerns about your vision?

◯ No ◯ Yes

19. Do you, or others, have concerns about your hearing?

◯ No ◯ Yes

MIDDLESEX HEALTH PRIMARY CARE –Wellness Assessment Form

Name: _____ DOB: _____ Date: _____

20. Do you have any dental concerns?

No Yes

21. Do you have trouble with bowel movements or controlling your urine?

No Yes *Please explain*: _____

22. Do you have any open wounds, sores, or areas of skin breakdown?

No Yes *Please explain*: _____

23. During the past 4 weeks, how much bodily pain have you generally had?

No pain
Mild pain
Moderate pain
Extreme pain

24. For each of the following activities, are you able to perform them *without help* OR *need some help*:

Activity	**Without Help**	**Need Help**
Using the toilet		
Bathing		
Dressing		
Eating		
Getting out of bed/ chair		
Walking		
Preparing meals		
Housework		
Shopping and errands		
Using the telephone		
Managing money		
Driving		
Taking medications		

25. Do you use any of the following special equipment?

Equipment	**No**	**Yes**	**Need**
Cane			
Walker			
Wheelchair			
Chairlift			
Bedside Commode			
Raised toilet seat			
Grab bars in bathroom			
Bath bench / Shower chair			
Life line			
Handrails on stairs			
Ramps			
Oxygen			
CPAP / BiPAP			
Hospital bed			
Protective undergarments (e.g. Depends)			
Catheter, feeding tube or colostomy bag			

26. Do you, or others, have concerns about your memory?

No Yes Maybe

27. Do you have someone available to help you if you need assistance?

No Yes Sometimes

28. Do you have a living will or advanced directive?

No Yes *(please bring a copy for our records)*

29. Do you have any additional questions or concerns?

No Yes *Please explain:* _____

_____

_____

_____

***PCP Signature:*_____ *Date:*_____**

Middlesex Health

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks how often have you been bothered by any of the following problems? (Please circle the number to indicate your answer for each item)

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1) Little interest or pleasure in doing things	○	○	○	○
2) Feeling down, depressed or hopeless	○	○	○	○
3) Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4) Feeling tired or having little energy	○	○	○	○
5) Poor appetite or overeating	○	○	○	○
6) Feeling bad about yourself or that you are a failure or have let yourself or your family down	○	○	○	○
7) Trouble concentrating on things such as reading the newspaper or watching television	○	○	○	○
8) Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9) Thoughts that you would be better off dead, or hurting yourself in some way	○	○	○	○

TOTAL SCORE: ☐

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat Difficult	Very Difficult	Extremely difficult
	○	○	○	○

Middlesex Health

Name: _____ Date: _____

Social Determinants of Health Screening

1. **In the past 12 Months, was there a time when you did not have a steady place to sleep or slept in a shelter (including now)?**

   ◯ Yes
   ◯ No
   ◯ Decline

2. **How hard is it for you to pay for the very basics like food, housing, medical care and heating?**

   ◯ Not hard at all
   ◯ Not very hard
   ◯ Somewhat hard
   ◯ Hard
   ◯ Very hard
   ◯ Decline

3. **In the past 12 months, has lack of transportation kept you from medical appointments or from getting medications?**

   ◯ Yes
   ◯ No
   ◯ Decline

4. **Within the past 12 months, you worried that your food would run out before you got the money to buy more?**

   ◯ Never true
   ◯ Sometimes true
   ◯ Often true
   ◯ Decline

5. **Within the last year, have you been afraid of your partner or ex-partner?**

   ◯ Yes
   ◯ No
   ◯ Decline