Dear ______________,

Thank you for choosing St. Luke Community Healthcare for your healthcare needs. As a Medicare patient, you can take advantage of one of three types of Medicare Annual Wellness Visits. If you are new to Medicare, you will be completing your Initial Preventative Physical Exam (IPPE). If you have been a Medicare patient for over 1 year, you will be completing your Initial Medicare Annual Wellness Visit or your Subsequent Medicare Annual Wellness Visit.

Explanation for each service below:

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Preventative Physical Exam (IPPE)</strong></td>
<td>“Welcome to Medicare” is only for new Medicare patients. This must be done in the 1st year as a Medicare patient.</td>
</tr>
<tr>
<td><strong>Initial Medicare Annual Wellness Visit (MAWV)</strong></td>
<td>At least 1 year after the “Welcome to Medicare” exam.</td>
</tr>
<tr>
<td><strong>Subsequent Medicare Annual Wellness Visit (MAWV)</strong></td>
<td>Once a year after the IPPE and Initial MAWV.</td>
</tr>
</tbody>
</table>

Your Medicare Annual Wellness Visit is focused on prevention and wellness. By participating in your Annual Wellness Visits your healthcare provider can obtain important information about your health and work with you to develop a plan to manage your healthcare needs.

What to expect during your Medicare Annual Wellness Visit:

- A limited physical exam to check your blood pressure, height, weight, and vision
- A discussion of services that allow our care team to closely monitor your health conditions and update your plan of care before office visits
- Counseling about preventative healthcare services, including important preventative cancer screens, vaccinations, and referrals for care, if needed
- An opportunity to discuss Advanced Care Planning and Advanced Directives
- Counseling on a healthy lifestyle

Before your appointment, you will be contacted for a Pre-appointment Interview. Please review and complete the attached documents and bring them with you to your appointment. Included in your packet are the following:

- Health Risk Assessment
- MyChoice Advanced Directives (or the Advanced Directives of your choosing)
- Montana Provider Order for Life-Sustaining Treatment (POLST)
- myHealth Patient Portal Card

*Please bring a list of all medications you are taking (prescribed and over-the-counter).*

We look forward to seeing you soon. If you have any questions about your packet, please call your primary care provider. You may also ask any questions during your pre-appointment interview.

Ronan- 126 6th Ave. S.W.  Polson- 104 Rufus Lane  Ridgewater- 107 Ridgewater Dr.  St. Ignatius- 330-6 Tract
Lane Ronan, Montana 59864  Polson, Montana 59860  Polson, Montana 59860  P.O. Box 1029
(406) 676-3600  (406) 883-2555  (406) 883-3737  St. Ignatius, Montana
59865  59860  59860  (406) 745-2781

A part of St. Luke Community Healthcare
A Message for Your Community Health Worker

Hi, my name is Shaina and I am the Community Health Worker at St. Luke. We are looking forward to seeing you for your Medicare Annual Wellness Visit. To prepare you for this visit, I or a member of the clinic staff, will be calling you to complete your pre-appointment interview. The pre-appointment interview gives me an opportunity to fully prepare you for your visit, ensure you have plenty of time with your care team in the clinic, and obtain important information about your physical and mental health.

I will be asking you to update:
1. Past Preventative Screens
2. Current Providers, Specialists, and/or Durable Medical Equipment Suppliers
3. Your current medication list and to bring a list of any medications you are taking

I will also ask you about:
5. Your current/past tobacco use and mental health status
6. Your fall risk

I will also provide education about myHealth Portal, which is a convenient way to keep in touch with your care team, have access your medical records 24/7, and receive automatic updates to changes in your record.
Patient’s Name: ___________________________________ D.O.B. _____ / _____ / ________

Primary Care Provider: ________________________________________________________________

Allergies: _______________________________________________________________________
_________________________________________________________________________________

In general, how would you rate your health?
☐ Excellent  ☐ Very Good  ☐ Good  ☐ Fair  ☐ Poor

How often do you get social/emotional support?
☐ All the time  ☐ Less than half the time
☐ More than half the time  ☐ Rarely
☐ Half the time  ☐ Not at all

Behavior Screen
1. How often do you take your medications as directed?
☐ Always  ☐ Sometimes  ☐ Seldom  ☐ I do not take any medications
2. How often do you use your seat belt?
☐ All the time  ☐ Some of the time  ☐ Rarely or not all

Function Screen
1. Please check any activities you need help with:
☐ Eating  ☐ Toileting  ☐ Bathing  ☐ Dressing  ☐ Moving in and out of bed or a chair  ☐ Walking
☐ Using the Phone  ☐ Transportation  ☐ Shopping  ☐ Meals  ☐ Housework  ☐ Laundry
☐ Managing of taking medications  ☐ Managing Finances  ☐ No assistance needed
2. Do you have trouble controlling your bladder?
☐ Yes  ☐ No

Home Safety Screen
1. Please check all that applies to your home
☐ Entry ways are well lit
☐ Sidewalks and entryways maintained
☐ Carbon Monoxide detector installed
☐ Smoke detectors are installed
☐ Unidentified or expired medications are thrown out

Continue on back of page.
What is your occupation?____________________________________________________________

Who do you live with?______________________________________________________________

**Hearing Loss Screen**

1. Please check anything that applies to how your hearing affects your life:

- ☐ No problems with hearing
- ☐ Embarrasses you when meeting new people
- ☐ Frustrates you when talking with family
- ☐ Have difficulty hearing when someone whispers
- ☐ Feel impaired by hearing problem
- ☐ Hearing causes difficulty when visiting people
- ☐ Attend religious services less often because of hearing
- ☐ Argue with family because of hearing
- ☐ Difficulty hearing radio or TV
- ☐ Hearing limits personal or social life
- ☐ Difficulty hearing in restaurant

During the past 30 days, how often did you eat 5 servings of fruits and vegetables per day?

- ☐ Every day
- ☐ Almost Every Day
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

How often do you eat out per week?_____________________________________________________

In the last 12 months, did you ever eat less than you thought you should because there wasn’t enough money?

- ☐ YES
- ☐ NO
- ☐ Don’t Know

Your weight over the past year?

- ☐ Stable
- ☐ Decreased >10lbs
- ☐ Increased >10lbs
- ☐ Other:_______________________

How many times per week do you exercise? _____Duration?_____Type?_____________________

Alcohol Use: ☐ YES ☐ NO If yes, how many drinks per day?______________

Drug Use: ☐ YES ☐ NO If yes, how much per day?______________

Thank you for filling out this survey. You will receive a call 2 days before your scheduled appointment from clinic staff to complete the pre-appointment interview. This interview ensures your time at the clinic is limited.

If you have any questions, please call your primary care provider.

Patient/Guardian Signature_________________________________Date____________________