

CENTER/PROVIDER NAME:		CENTER/PROVIDER #:			
ENROLLEE MEDICAID #:	DOB:	AGE:	SEX:		
	REVIEWER #1:	REVIEWER #2:	DATE:		
			YES	NO	N/A
HISTORY ASSESSMENT					
1. Health screening performed					
2. Past medical and surgical history documented					
3. Relevant family and social history documented					
4. Allergy documented					
PHYSICAL ASSESSMENT					
5. Was a BMI documented for the current or prior year? If yes, please obtain a copy of the record.					
6. Blood pressure recorded for every visit					
LABORATORY OR DIAGNOSTIC TESTS					
7. Mammogram (Every 1-2 years) (Women ≥ 40)					
8. Pelvic/Pap Smear (At least every 3 years) (Women ≥ 21) or documentation of referral to specialist					
9. Colorectal cancer screening (any one of the following: fecal occult blood test (annually), sigmoidoscopy every 5 years, double contrast barium enema every 5 years, colonoscopy)					
10. CBC (≥21)					
11. Fasting Lipid Profile ((≥20)					
12. HbA1c (For diabetes patient only)					
13. Urinalysis (≥21)					
EDUCATION OR PLANNING					
14. Education appropriate to age, risk factors, and medical condition provided.					