

## Cerner PowerChart Ambulatory EDUCATION

Medicare Annual Wellness Visit PowerForm	
The Medicare Annual Wellness Visit PowerForm is compl	eted as part of a patient's annual wellness visit clinical intake.
The Medicare Annual Wellness Visit PowerForm can be a	ccessed from the Ambulatory Nursing Workflow page or from
AdHoc.	
1 Archulator Numire Martheur	Ambulatory Nursing ×
1. Ambulatory Nursing Workflow:	Chief Complaint Vital Signs + V All Visits Last 12 months
Signs component.	Documents (1) Today Ambulatory Vitals Height Weight
b. Select Medicare Annual Wellness Visit.	Vital Signs up Datient Provided Vital Signs
	Histories bpm Ambulstony Comprehensive
	Allergies (1) Intake
	Immunizations kg b Medicare Annual Wellness Visit
	Recommendations Height/Length Pediatric Ambulatory Intake
2. AdHoc:	
a. Click AdHoc on the PowerChart tooldar.	AdHoc
c. Click Chart.	or Charting
Contra Additi	ional Assessments
🗂 Behar 🛅 Cardio	vioral Health Ambulat 🔲 🗈 Comprehensive Intake
	YN E Nurse Visit
🗅 All Ite	ms Diguick Intake
	Healthcare Decision Maker - Amb
	Chart Close
PowerForm Navigation	
<ul> <li>PowerForms are divided into pages on the left.</li> </ul>	
Blue highlight indicates the current page that is o	open. Intake Summary
<ul> <li>Indicates there is a required field on a page that it</li> </ul>	must be answered before signing the PowerForm.
	* Healthcare Decision Maker
<ul> <li>Required fields will display as yellow.</li> </ul>	
<ul> <li>Light grey indicates a page that is available to do</li> </ul>	cument on and is unopened. Allergies and Medications
<ul> <li>Light blue indicates a page that has been opened</li> </ul>	PHQ-2 and PHQ-9
Dark grey indicates a page that is not available to	o document on. (It may become available based on responses
entered in other areas of the PowerForm.	Detailed Vitals and Measurements
• To complete and sign a PowerForm.	
<ul> <li>Cancels documentation of the PowerForm.</li> </ul>	The form will close without saving any entered information.
Saves the information entered on the Power	rForm without completing. This is not recommended for use.
<ul> <li>Clears all information on the current page o</li> </ul>	If the PowerForm.
<ul> <li>Image: Antipage of the Power</li> <li>Image: Antipage of the Power</li> </ul>	Form.
Clinical calculator offers clinical formulas an	id conversions.



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#### Intake Summary

### **Patient Summary**

The following are **optional** for documentation:

- 1. Chief Complaint: Enter the patient stated chief complaint.
  - Communication Preference: Select or update as needed. This must be selected to use patient invitations.
  - History of Present Illness Nursing Note: HPI is optional and should be used only as directed by the practice.

	Intake Summary	Patient Summary
*	Detailed Vitals and Measurem	Chief Complaint 1 Communication Preference 2
	PHQ-2 and PHQ-9	
	Allergies and Medications	○ No Preference
*	Social History	O Printed Letter
	Opioid Risk Tool - Opioid Use	Keset Submit
	Family History	History of Present Illness, Nursing Note
	Procedure and Surgical Histo	
	Problems and Diagnosis	Segoe UI 🗸 9 🗸 🛞 음 들 들
	Infectious Disease Risk Scree	

#### Vitals

All the following fields are **mandatory** for documentation, except Heart Rhythm.

- 1. Blood Pressure
- 2. Pulse Rate: Document beats per minutes when auscultated or palpated. Document as Heart Rate Monitored: when a machine is used to record beats per minute. Either method satisfies the mandatory requirement.
- 3. Respiratory Rate
- 4. O2 Sat
- Temperature: Documentation is in Degree Celsius and can be done as oral, temporal, or tympanic. One method satisfies the mandatory requirement.
- Heart Rhythm (optional)
- 7. Pain Scale: Select the Pain Scale Used and
  - document the Pain Level. Pain Comments is available to enter additional comments.

#### Measurements

It is **mandatory** to enter a **measured** Height and Weight. **Both** Height **and** Weight need to be measured to calculate a Measured Body Mass Index (BMI). An accurate BMI is needed for ordering a correct BMI code.

Measureme	Measurements											
DISPLAY ONLY Field below displays the last Height Measured for the last 364 days												
Height/Length Measured: 182.88 cm (03/13/23 10:09:00)												
Weight Measured	Height/Length Measured	BMI Measured	Waist Circumference									
Weight Non Measured	Height/Length Non Measured	BMI Non Measured	Pre-Pregnancy Weight	Calculated Cumulative Weight Gain								
kg	cm		kg	kg								
Reason Measureme	ents Not Obtained	Measurements Cor	nments									

Vitals	1				
SBP / DBP		Blood Pressu	ire Source		
If BP is greater than 14 repeat after 5 min or lo Documet on Vital Signs Measurements form.	o/90 nger. and	C It arm w/BP C It leg w/BP C It leg w/BP C It leg w/BP	machine Oltrarm, m machine Oltrag, ma Prachine Ortarm, m machine Ortag, ma	anually C It arm, palpated nually C It leg, palpated anually C rt arm, palpated anually C rt leg, palpated	<ul> <li>Left forearm, radial cuff</li> <li>Right forearm, radial cuf</li> </ul>
Pulse Rate Heart Rate Monitored	Resp. Rate	02 Sat	Temperature Oral	Temperature Temporal	Temperature Tympanic DegC
Heart Rhythm	Pain Scale U	Jsed ~	Pain Level	Pain Comments	
O Hegular	Right click i above to se Reference	in field 7			



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#### Healthcare Decision Maker

Healthcare Decision Maker is **required** to complete and/or update. Healthcare Decision Maker is used to capture information regarding healthcare decision making, Guardian, and Advance Directive/DPOAH for the patient. Follow practice guidelines for documentation requirements.

Intake Summary									
Healthcare Decision Maker - Medicare	Healthcare Decision Maker								
Detailed Vitals and Measurements	The purpose of this form is to capture information regarding healthcare decision making								
PHQ-2 and PHQ-9	Is noticed surroutly oble to ensure these substitutes								
Allergies and Medications	Definitions of Legal Terminology								
* Social History									
Opioid Risk Tool - Opioid Use Disorder									
Family History	Guardian								
Procedure and Surgical History	If this actions has a CHARDIAN and a sony is in the actionsts' short, it will be listed below.								
Problems and Diagnosis									
Infectious Disease Risk Screening	lease select 'No' in field below as this patient does not have a Letter of Guardianship in their medical record								
Health Risk Assessment									
Functional Assessment	This patient has a Guardian								
Hearing and Vision Screening	O Yes O No								
Home Safety Screen									
Geriatric Depression Scale-15	It is not necessary to continue documenting this form if the patient has a Court Appointed Guardian								
Mini-Cog	Advance Directive / DPOAH								
Conley Fall Risk Scale									
Instrumental ADL Adult	If this patient has an AD/DPOAH and a copy is in the patients' chart, it will be listed below								
Review of Systems	This patient does not have an Advance Directive/DPOAH medical record								
<ul> <li>Education Needs</li> </ul>									
Behavioral Pain Score	Does the nationt have an								
FLACC Pain Score	Advance Directive or DPOAH								
NIPS Pain Score	O Yes O Unknown If yes and a copy is not on file, please ask the patient to								
NPASS Pain Score	O No bring in a copy of the document so it can be added to their medical record								

#### **Depression Screening**

PHQ-2 and PHQ-9 depression screening is **mandatory** to document. Document **both** PHQ-2 and PHQ-9 questionnaire, regardless of the PHQ-2 score, for the Medicare Annual Wellness Visit.

Intake Summary	PHO-2 and PHO-9 De	pression Sc	reening Ouestionnaire							
Detailed Vitals and Measurements										
PHQ-2 and PHQ-9	Over the last 2 weeks, how often have you been bothered by any of the following problems?									
Allergies and Medications	d title to to the plan and in	O Not at all	O More than half the days							
Social History	1. Little Interest or Pleasure in Doing Things	O Several days	O Nearly every day							
Family History										
Obstetrical History	2 Fooling Down, Donwood or	O Not at all	O More than half the days							
Procedure and Surgical History	Hopeless	O Several days	O Nearly every day							
Problems and Diagnosis										
Infectious Disease Risk Screening	BUD 2 Com									
Psychosocial and Spiritual	PHQ-2 Score	Score = 0 No furth	her action required							
Conley Fall Risk Scale		Score = 1-6 Complet	te the PHQ9 below							
Instrumental ADL Adult	2. Tasukis Falling on Charling Asian	O Not at all	O More than half the days							
<ul> <li>Education Needs</li> </ul>	3. Trouble railing or Staying Asleep	U Several days	Nearly every day							
Healthcare Decision Maker - Amb										
Interpreter Services	A Factor Three and the factor	O Not at all	O More than half the days							



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### Allergies and Medications

Review of allergies and medications is **required** at every patient visit. The review can be done from the Ambulatory Nursing Workflow or Medicare Annual Wellness Visit PowerForm.

#### Allergies:



- a. Click the button to add an allergy to the list.
- b. Select a current allergy on the list, then click the button to Modify an existing allergy.
- c. When the allergy review is complete, click the Mark All as Reviewed button.
- Allergies С Iter by Status All Mark All as Reviewed 🕂 Add Modify No Known Allergies а hce Terminology Category Read Latex Environm. Hive Allergy No Known M... Cerner Drug
- Complete steps for Allergy Reconciliation can be found on Clinical EHR Education <u>website</u>.

**Note**: If the allergy review is done on the Intake form, the Complete Reconciliation button in the Allergies component on the Ambulatory Nursing Workflow will still need to be clicked for meaningful use credit.

#### Medications:

- a. Click Document Medication by Hx to begin the medication review. Medication compliance is required when reviewing medications. This should include all prescribed and over the counter medications/supplements.
- b. Clicking Add will add a medication order.

Medications				
ba			🛃 Print 🗷 2 minutes	ago
🕂 Add 🎝 Document Medication	by Hx 📴 External Rx History 👻 🍹	Reconciliation Status Heds History	Admission  Outpati	ient
View	Display: All Active Medications, All Inactive Medications 24 Hrs	Back 🧹	Customize V	/iew
Orders for Signature Medication List	\$ Order Name/Details A	Order Com	Ordering Physician	Stat
Non Categorized	△ Medications		Clark MD, Kally I	Dre
Patient Care     Vital Signs	1 Tab, Oral, Daily, 30 Tab, 0 Refill(s)		Clark IVID, Kelly J	PIE

- c. Send a message to the rendering or primary care provider regarding any medications that the patient reports taking incorrectly or not compliant.
- d. When the medication history is completed, the Meds History Reconciliation Status will display a green check mark.
  - Reconciliation Status
     Meds History
- Complete steps for Documenting medications by history can be found on the Clinical EHR Education website.

### Social History

Social History is **required** to be reviewed at every patient visit. Documentation should include, at a minimum, **Tobacco status**, **Alcohol**, **and Substance Use**.

- Psychosocial/Spiritual is required for documentation only one time and will be carried across encounters for review.
- Abuse/Neglect screening is required once every year for all patients and must be completed at the patient's Wellness Visit if required.



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- Follow practice guidelines for additional Social History documentation.
- See Instructions for making changes to Social History for steps on modifying and adding documentation.

P Medicare Annual Wellness Visit - AMBCERNED, ERNEST									
🗸 🖬 🛇   🖏 🗖 🛧 🗣   🎟 [									
*Performed on: 03/10/2023	✓ 1312								
Intake Summary	Social History								
* Healthcare Decision Maker - Medicare									
Detailed Vitals and Measurements	Instructions for making	changes to Social History documentation							
PHQ-2 and PHQ-9	If no documentation prese	ent, right click and Add							
Allergies and Medications	If documentation present,	, and no error message, right click and modify							
Social History	If documentation present,	, and error message present, right click Add, then right click and	remove old docum	nentation					
Opioid Risk Tool - Opioid Use Disorder									
Family History	Mark all as Reviewed butto	on is no longer active							
Procedure and Surgical History		mmy							
Problems and Diagnosis	Mark all as Reviewed								
Infectious Disease Risk Screening	Social								
Health Risk Assessment	🕂 Add 🛒 Modify	Display: Active ~							
Functional Assessment	Category	Catagori							
Hearing and Vision Screening	Tobacco	Smoking Status: Never (less than 100 in lifetime).	10/10/2022 11:59	Ambrnipn, 20					
Home Safety Screen	Electronic Cigarette/Va								
Geriatric Depression Scale-15	Alcohol	None	10/10/2022 11:59	Ambrnlpn, 20					
Mini-Cog	Substance Use								
Conley Fall Risk Scale	Exercise								
Instrumental ADL Adult	Sexual								
Review of Systems	Home/Environment								
* Education Needs	Employment/School		10/10/2022 11 50						
	Psychosocial/Spiritual	No Spiritual/cultural preferences:	10/10/2022 11:59	Ambrnipn, 20					
Benavioral Pain Score	** Abuse/Neglect	Question not asked	10/10/2022 11:59	Ambrniph, 20					
	Reference Policy for In								
	If Current or Quit with Smoking Cessation Co								
	Patient asked, during any previous encounter in the past 24 months, about the use of Tobacco								



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### **Opioid Risk Tool – Opioid Use Disorder**

The Opioid Risk Tool is **mandatory** to be administered to all patients.

Intake Summary * Healthcare Decision Maker - Medicare		Opioid Risk Tool - Opioid Use Disorder								
Detailed Vitals and Measurements	This tool should be ac	dministered to patients upon an initial visit prior to beginning or continuing opioid therapy for pain management								
PHQ-2 and PHQ-9		miniscered to patients apon an initial voic provice beginning or contenting opiola energy for pair management								
Allergies and Medications	Family history of si	ubstance abuse								
* Social History	Alcohol									
Opioid Risk Tool - Opioid Use Disorder										
Family History	lllegal drugs	O Yes O No								
Procedure and Surgical History	Precription Drugs									
Problems and Diagnosis	r roonpaon brago									
Infectious Disease Risk Screening	Personal history of	substance abuse								
Health Risk Assessment	Alcohol									
Functional Assessment	Alconor									
Hearing and Vision Screening	Illegal drugs									
Home Safety Screen										
Geriatric Depression Scale-15	Precription Drugs	O Yes O No								
Mini-Cog										
Conley Fall Risk Scale	Age between	🖲 No								
Instrumental ADL Adult	16-45 years									
Review of Systems	Psychological dise	ease								
* Education Needs	ADD, OCD,	O Yes O No								
Behavioral Pain Score	bipolar,									
FLACC Pain Score	schizophrenia									
NIPS Pain Score	Depression	O Yes O No								
NPASS Pain Score										
	Score and interpre	tation								
	A score of 2 or lower	indicates low risk for future opioid use disorder.								
	A score of 3 or greater indicates a high risk for opioid use disorder.									
	Score									
	Interpretation	C Low risk for future opioid use disorder O High risk for opioid use disorder								

### **Family History**

Family History is **mandatory** to be reviewed and/or updated at every patient visit. Family history review includes first degree relatives: parents, siblings, and offspring. Pertinent positive **and** negative information should be documented.

- a. Click Add button to add and/or modify any health history for a family member. Refer to step 2 for more information.
- b. The Display drop-down allows for different viewing options.
- c. Once the Family History review is complete, click Mark all as Reviewed.





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- 2. If the Add button is clicked, the Add Family History screen will appear.
  - a. Family members will be listed at the top from left to right. Names and demographics can be entered by left clicking on the relationship. Family members that do not exist should be removed by right clicking on the relationship.
  - b. Family relationships can be added by clicking the drop-down Add Family Member.
  - c. Click the QuickList magnifying glass to search for and create a list of histories not found in the General Family History list.
  - d. Selecting negative here will document a negative history for the selected condition for all family relationships listed.
  - e. Click in the white or blue column under each family member to document a negative or positive history.
  - f. Click on Add Group to add additional groups of histories for review.
  - g. Once complete, click OK.

amily History							
Add Familu History							
ask Hardeter 2/9/2022 12/24 PM EET hu As		anus Mada					- Add Esmily Mamb
ast opdate: 273/2022 12:34 PM EST by Ar	nompn, 20 🔲 r	ocus mode					<ul> <li>Add Family Member</li> </ul>
	Relationship	Father	Mother	Brother	Sister	Son	Daughter
<b>a</b>	Name	Bob	Jane				
	Health Status	~	~	$\sim$	~	$\sim$	$\sim$
🖯 QuickList	- 🔍 🖸						
🛛 General Family History							
Alcohol abuse	-						
Alzheimer's disease	-						
Breast cancer	-						
Cancer	-						
Dementia	-						
Developmental delay	-						
Diabetes mellitus	-	+					
Heart attack	-						
Hypertension	-						
Mental disability	-						
Osteoporosis	-						
Prostate cancer	-						
Stroke	-						
Substance abuse	-						
Suicide	-						
Tuberculosis							
	d			е	е		g
Add Group							DK Cancel



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### **Procedure and Surgical History**

Procedure and Surgical History is mandatory to be documented and/or updated at every Medicare Annual Wellness Visit.

- a. Click the **\*** Add button to add a procedure/surgery to the history list.
- b. Click the Mark all as Reviewed button when the review is complete.

	Intake Summary	Procedure / Surgical History							
	Detailed Vitals and Measurements								
	PHQ-2 and PHQ-9								
Note: Complete steps for adding	Allergies and Medications	Mark all as Heviewed							
and documenting	Social History	Procedures							
Procedure/Surgical History can be	Family History	🕂 Add a Modify Display: Active							
found on the Clinical EHR Education	Obstetrical History	Procedure Date Provider							
website.	Procedure and Surgical History	Implantation of heart pac							
	Problems and Diagnosis	Vasectomy							

#### **Problems and Diagnosis**

Problems and Diagnosis allows viewing of problems and diagnoses in the same window. This should be reviewed and/or updated on the Ambulatory Nursing Workflow page. It is required to document patient stated medical problems at every visit.

Intake Summary	Pro	blem	is and	Visi	it Diag	gnosis	5						
<ul> <li>Healthcare Decision Maker - Medicare</li> </ul>	د <sub></sub>												
Detailed Vitals and Measurements	4	/lark all as	Reviewed										
PHQ-2 and PHQ-9	Dia	Diagnosis (Problem) being Addressed this Visit Add Modify Sconvert Display: All											
Allergies and Medications	+												
* Social History							_				_		
Opioid Risk Tool - Opioid Use Disorde		Priority	Condition	Name		Clinical Dx	*		J,	Confirmation	Date	Vocabulary	
Family History		1	<ul> <li>Chest pai</li> </ul>	n		Chest pair	n, uns	pecified		Confirmed	10/12/2022	ICD-10-CN	1
Procedure and Surgical History			✓ ATID			Unspecifi	ed atri	al fibrillati		Confirmed	10/17/2022	ICD-10-CN	<i>n</i>
Problems and Diagnosis													
Infectious Disease Risk Screening	Pro	blems											
Health Risk Assessment		Add	Modi	łu 🛨	Convert	No. No.	) Chror	nic Problems		Display: All			
Functional Assessment				, · · ·		20			1				
Hearing and Vision Screening		Condition	1 Name		Name of Pr	oblem 🔺		Vocabulary		Last Updated By	Confirmation	Last Updated	0
Home Safety Screen	D×	Afib			Atrial fibri	llation		SNOMED C	Т	Ambrnipn, 19	Confirmed	10/17/2022	
Geriatric Depression Scale-15		Cholelit	hiasis		Biliary cal	culus ivo dicordo		SNOMED C	T	Ambrnipn, 19	Confirmed	10/17/2022	•
Mini Con	Dx	Osteoar	throsis		Osteoarth	ritis	· · · ·	SNOMED C	т	Ambrnipn, 19 Ambrnipn, 19	Confirmed	10/17/2022	
	Dx	Diabete	s mellitus, ty	pe 2	Type 2 dia	betes melli	tus	SNOMED C	т	Ambrnipn, 19	Confirmed	10/17/2022	
Conley Fall Risk Scale													
Instrumental ADL Adult													
Review of Systems													
<ul> <li>Education Needs</li> </ul>													

Note: Complete steps for adding and documenting Problems and Diagnosis History can be found on the Clinical EHR Education website.



### Cerner PowerChart Ambulatory EDUCATION

#### Infectious Disease Risk Screening

Infectious Disease Risk Screening page is **optional** for documentation of Infection History, Infectious Disease Risk Factors/Symptoms, Tuberculosis Risk Factors/Symptoms, and several other family member and travel history information. Follow practice guidelines for documentation requirements.

Intake Summary	Infectious Disease Risk	< Scree	ning			
Detailed Vitals and Measurements PHQ-2 and PHQ-9	Infection History				Hepatitis B Description	Hepatitis C Description
Allergies and Medications	,					
Allergies and Medications		Yes	No	Comment	O active	O active
Social History	Chickenpox				O Non-Treated	O Non-Treated
Family History	Chlamydia				O Recent exposure	O Recent exposure
	History Genital Herpes, Patient/Partner				O Treated	O Treated
Obstetrical History	Genital Herpes Outbreak Last 14 Days					
Procedure and Surgical History	Gonorrhea					
Problems and Diagonasia	HIV Exposure				Date of Hepatitis B Vaccin	ation
Problems and Diagnosis	HPV					
Infectious Disease Risk Screening	History of Rash/Virus in Last Month					
Psychosocial and Spiritual	History of Recent Positive TB Results					
	Syphilis					
Conley Fall Risk Scale	-				Recent Travel History	
Instrumental ADL Adult	Infectious Disease Risk Factors/Sym	ptoms			O No. O Yes	
✓ Education Needs		Yes	:	No		
Healthcare Decision Maker - Amb	Chills				Recent Travel Detail	
	Fever				Recent Haver betan	
Interpreter Services	Unusual Fatigue					
Review of Systems	Headache					
Pehrusiami Prin Soare	Runny or Stuffy Nose					
Denavioral Fain Score	Sore Throat					

#### Health Risk Assessment

The Health Risk Assessment Questionnaire is mandatory. Complete all 25 questions for documentation.

Intake Summary	Health Risk Assessment Questionnaire		
* Healthcare Decision Maker - Medicare			
Detailed Vitals and Measurements	1. Are there hazards in your house that might hurt you?	O No	O Yes
PHQ-2 and PHQ-9	2. Have you fallen in the past year?	O No	O Yes
Allergies and Medications	3. Are you worried you might fall?	O No	O Yes
<ul> <li>Social History</li> </ul>			<u> </u>
Opioid Risk Tool - Opioid Use Disorder	4. Do you use a cane or walker?		
Family History	5. Do you need someone to help you get up in the morning?	O No	O Yes
Procedure and Surgical History	6. In the past four weeks, have you fallen or felt dizzy when standing up?	O No	O Yes
Problems and Diagnosis	7. Because of any health problems, do you need the help of another person with your	O No	O Yes
Infectious Disease Risk Screening	personal care needs such as eating, bathing, dressing, or getting around the house?		
Health Risk Assessment	8. Do you have trouble consistently taking or remembering to take all of your	O No	O Yes
Functional Assessment	medications as prescribed?	_	
Hearing and Vision Screening	9a. During the past four weeks, have you had pain present?	O No	O Yes
Home Safety Screen	9b. Primary Pain Location:		
Geriatric Depression Scale-15			
Mini-Cog	9c. Numeric Rating Scale		
Conley Fall Risk Scale	Numeric Rating Pain		
Instrumental ADL Adult	5000		
Review of Systems	10. Consume of the places with a firm thing distances without help? (For superstances		0.11
<ul> <li>Education Needs</li> </ul>	you travel alone on buses or taxis, or drive your own car?)	U Yes	U NO
Behavioral Pain Score	11. Can you go shopping for groceries or clothes without someone's help?	O Yes	O No
FLACC Pain Score			<u> </u>
NIPS Pain Score	12. Can you prepare your own means?		U NO
NPASS Pain Score	13. Can you do your housework without help?	O Yes	O No



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#### Functional Assessment

Functional Assessment – ADL Evaluation Index is used to assess the level of assistance needed for each ADL function and get an accurate ADL Index Score. It is **mandatory** to complete **all** six ADL categories.

• A score of 11 or less indicates a problem of Activity Intolerance.

Intake Summary	Functional Asse	ssment - ADL E	aluation Index
<ul> <li>Healthcare Decision Maker - Medicare</li> </ul>	Indicate a level of accistance	for each ADL function to obta	in an accurate ADL Index Score
Detailed Vitals and Measurements	Indicate a level of assistance		In an accurate ADE Index Score
PHQ-2 and PHQ-9	Bathing	Dressing	Toileting
Allergies and Medications	O Independent (2) O Requires assistance (1)	<ul> <li>Independent (2)</li> <li>Requires assistance (1)</li> </ul>	<ul> <li>Independent [2]</li> <li>Requires assistance (1)</li> </ul>
<ul> <li>Social History</li> </ul>	O Dependent (0)	O Dependent (0)	O Dependent (0)
Opioid Risk Tool - Opioid Use Disorder			
Family History	Transferring Bed or Chair	Continence	Feeding
Procedure and Surgical History	O Independent (2)	O Independent (2)	O Independent (2)
Problems and Diagnosis	O Requires assistance [1]	<ul> <li>Hequires assistance [1]</li> <li>Dependent (0)</li> </ul>	Independent with assistive device (2)     Requires assistance (1)
Infectious Disease Risk Screening	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	O Dependent (0)
Health Risk Assessment			
Functional Assessment	ADL Index Score (ref)		
Hearing and Vision Screening			
Home Safety Screen			
Geriatric Depression Scale-15	Higher total score reflects		
Mini-Cog	higher level of independence:		
Conley Fall Risk Scale	12 – Total independence		
Instrumental ADL Adult	6 = Moderate dependence		
Review of Systems	0 = Maximum dependence		
Education Needs	A score of 11 or less		
Behavioral Pain Score	Activity Intolerance		

#### Hearing and Vision Screening

Hearing and Vision Screening Comments are **mandatory**. Document Hearing and Vision concerns using the Comments fields.

Type any patient reported concerns in the appropriate Comments field(s), for example: patient uses hearing aids. If the patient has no concerns, type "No concerns" in the Comments field(s).

Intake Summary	Hearing Sc	reen			
* Healthcare Decision Maker - Medicare	Tympanogram,	Tympanogram,	Audiogram Result,	Audiogram Result,	
Detailed Vitals and Measurements	Left Ear	Right Ear	Right Ear	Left Ear	Hearing Screen Comments
PHQ-2 and PHQ-9	~	~	~	~	
Allergies and Medications					
* Social History					
Opioid Risk Tool - Opioid Use Disorder	Vision Scre	en			
Family History	VISION SCIE				
Procedure and Surgical History	Left Eye	Right Eye	Vision Test Type	Vision Screen Comm	ients
Problems and Diagnosis	~	~	~		
Infectious Disease Risk Screening					
Health Risk Assessment					
Functional Assessment	Copyright© Cerner Cor	poration. All rights reserv	ved.		
Hearing and Vision Screening					
Home Safety Screen					



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### Home Safety Screening

Home Safety Screening is mandatory. Document as many of the screening questions as possible.

Intake Summary	Home Safety Screer	ning			
<ul> <li>Healthcare Decision Maker - Medicare</li> </ul>	Are emergency numbers kept	Are all household members	Are working smoke alarm(s)		
Detailed Vitals and Measurements	by the phone and regularly updated?	aware of the dangers of smoking, especially in bed?	and fire extinguisher(s) available for use?	Do all household members know how to use them?	
PHQ-2 and PHQ-9		O Yes O No	O Yes O No	O Yes O No	
Allergies and Medications					
* Social History	Are firearms stored unloaded	Have throw rugs been	Are non-slip mats in all	Do all stairways have a railing	
Opioid Risk Tool - Opioid Use Disorder	and securely locked?	removed or fastened down?	O Yee O No	or banister?	
Family History					
Procedure and Surgical History	Are sidewalks and all outdoor		Are all electrical cords in working	order,	
Problems and Diagnosis	steps clear of tools, toys, and other articles?	stairs free of clutter?	easily seen, and not run under rugs/carpets or wrapped around	nails?	
Infectious Disease Risk Screening	O Yes O No	O Yes O No	O Yes O No		
Health Risk Assessment					
Functional Assessment	Comments				
Hearing and Vision Screening					
Home Safety Screen					
Geriatric Depression Scale-15					

#### **Geriatric Depression Scale-15**

Geriatric Depression Scale-15 page is available, but **not required** for depression screening for geriatric patients. (The PHQ-2 and PHQ-9 depression screening is used).

A total score will be automatically calculated to grade the degree of depression. Follow practice guidelines for documentation requirements and follow up.

Intake Summary	Geriatric Depression Scale	-15
* Healthcare Decision Maker - Medicare	Genatric Depression Scale	15
Detailed Vitals and Measurements		and the second
PHQ-2 and PHQ-9	Please select the best answer for now you felt over	er the past week.
Allergies and Medications	Are you basically satisfied with your life?	
<ul> <li>Social History</li> </ul>		O No
Opioid Risk Tool - Opioid Use Disorder		
Family History		0.84
Procedure and Surgical History	activities and interests?	
Problems and Diagnosis		
Infectious Disease Risk Screening		
Health Risk Assessment	Do you feel that your life is empty?	
Functional Assessment		
Hearing and Vision Screening		
Home Safety Screen	Do you often get bored?	O Yes
Geriatric Depression Scale-15	bo you orten get borear	O No
Mini-Cog		
Conley Fall Risk Scale		
Instrumental ADL Adult	Are you in good spirits most of the time?	
Review of Systems		
* Education Needs		
Behavioral Pain Score	Are you afraid that something bad is	O Yes
FLACC Pain Score	going to nappen to you?	U No
NIPS Pain Score		



### Cerner PowerChart Ambulatory EDUCATION

#### Mini-Cog

Mini-Cog Test is a **mandatory** test used to evaluate the patient for cognitive impairment.

- Patients scoring negative for cognitive impairment will require no further action.
- However, patients scoring **positive** for cognitive impairment **must** complete the St. Louis Mental Exam (SLUMS) paper form. Follow practice guidelines for any additional documentation requirements.

Intake Summary	Mini- Cog Test						
Healthcare Decision Maker - Medicare	Administration	Special Instruction	าร				
Detailed Wals and Measurements PHQ-2 and PHQ-9 Allergies and Medications Social History Opioid Risk Tool - Opioid Use Disorder Family History Proceedure and Surgical History Problems and Tampasis	Authinistration 1. Get patient's attention and ask him or her to remember three unrelated words. Ask patient to repeat the words to ensure the learning was correct. 2. Ask patient to draw the	Allow patient three     The following wave     The following wave     Version 1 Version 2     o Banana o Daughter     o Sunrise o Heaven     o Chair o Mountain     - Either a blank piece	e tries, then go lists have bee Version 3 o Village o Kitchen o Baby e of paper or a	to next item n validated i o River o Nation o Finger	n a clinical Version 5 o Captain o Garden o Picture circle (othe	study:1- Version o Leade o Seaso o Table r side) m	3 6 r n ay be used.
Infectious Disease Risk Screening Health Risk Assessment Functional Assessment Hearing and Vision Screening	face of a clock. After numbers are on the face, ask patient to draw hands to read 10 minutes after 11:00 (or 20 minutes after 8:00).	<ul> <li>A correct respons, positions AND the</li> <li>These two specific</li> <li>A clock should not</li> <li>Refusal to draw a</li> </ul>	e is all numbers hands pointing times are mor be visible to t clock is scored	placed in ap to the 11 a re sensitive t he patient d l abnormal.	pproximately nd 2 (or the han others uring this ta	y the cor e 4 and 8 ask.	rect 3).
Home Safety Screen Geriatric Depression Scale-15	3. Ask the patient to recall the three words from Step 1.	Ask the patient to r	ecall the three	words from :	Step 1.		
Mini-Cog Conley Fall Risk Scale Instrumental ADL Adult Review of Systems	CDT Score [ # or Recalled Words [	O Normal O Abnormal					
Education Needs Behavioral Pain Score FLACC Pain Score	Mini-Cog Score	Negative for cognitive impairment	O Positive for cog	initive impairment			
NIPS Pain Score		Scor	ing				
NPASS Pain Score	3 recalled wo 1-2 recalled 1-2 recalled v 0 recalled wo	rds words + normal CDT words + abnormal CDT rds	Negative for Negative for Positive for c Positive for c	cognitive imp cognitive imp ognitive impa ognitive impa	airment airment irment irment		Remember to scan in clock face drawing

### **Conley Fall Risk Scale**

The Conley Fall Risk Scale is used to score patient's fall risk. A full assessment is mandatory for documentation.

Intake Summary	Conley Fall Risk Sca	ale	
Detailed Vitals and Measurements			
PHQ-2 and PHQ-9	History		
Allergies and Medications	Months, Including Since		scores 2
Social History	Admission		
Family History	Observations		
Obstetrical History	Impaired Judgment/Lack	O Yes O No	Yes response
Procedure and Surgical History	of Safety Awareness		scores 3
Problems and Diagnosis	A 19 11		Vac rosponso
Infectious Disease Risk Screening	Agitation		scores 2
Psychosocial and Spiritual			
Conley Fall Risk Scale	Impaired Gait, Shuffle,	O Yes O No	Yes response
Instrumental ADL Adult	Wide Base, Unsteady Walk		scores 1
✓ Education Needs			
Healthcare Decision Maker - Amb	Direct Questions (Do Tou)		
Interpreter Services	Ever Experience Dizziness or Vertigo	O Yes O No	Yes response scores 1
Review of Systems			
Behavioral Pain Score	Ever Wet or Soil Yourself	O Yes O No	Yes response
FLACC Pain Score	on Way to Bathroom		scores 1
NIPS Pain Score			
NPASS Pain Score	Fall Risk Score		
		Patient is at risk for falls if Conley score is greater than or equal to 2	



Cerner PowerChart Ambulatory EDUCATION

### Instrumental ADL Adult

Instrumental Activities of Daily Living is **mandatory** to complete. Document levels of independence for as many categories as possible.

Use the following three levels of assistance for documentation to accurately track changes:

- Complete independence
- Modified independence
- Total assistance

Intake Summary	Instrumental	Activities of	Daily Living	1
Detailed Vitals and Measurements				
PHQ-2 and PHQ-9		Complete independence Mo	odified independence S	uper
	Meal Prep			
Allergies and Medications	Writing			
Social History	Reyboarding Phone Use			
Family History	Money Management			
Obstatrical History	Grocery Shopping			
Obstetrical history	Clothing Care			
Procedure and Surgical History	Light Cleaning			
Problems and Diagnosis	Heavy Cleaning			
Trobionio ana biagnosio	Community Transportation			
Infectious Disease Risk Screening	Community Mobility, Safety			
Psychosocial and Spiritual	Care of Others Medication Management			
Conley Fall Risk Scale	Other IADL			
Instrumental ADL Adult				
✓ Education Needs	Child Rearing			
Healthcare Decision Maker - Amb				
Interpreter Services				
Review of Systems	Other IADI Information			
Behavioral Pain Score				
FLACC Pain Score				
NIPS Pain Score				

#### **Review of Systems**

Review of Systems page is available, but **not required** for documentation. Follow practice guidelines for documentation requirements.

Intake Summary	Review of Sv	sten	າຣ		
Detailed Vitals and Measurements		0.0011			
PHQ-2 and PHQ-9	General:				
Allergies and Medications		١	íes 🛛	No	
Social History	Weight Change >10lbs				
	Difficulty Sleeping				
Family History	Blood Transfusion				
Obstetrical History	Fever				
Presedure and Constant Utation	Fatigue				
Procedure and Surgical History	Night sweats				
Problems and Diagnosis	Diaphoresis				
Infectious Disease Bisk Screening	Diaphoresis				
- · · · · · · · · · · · · · · · · · · ·	Head and Neck:				
Psychosocial and Spiritual	field and field				
Conley Fall Risk Scale			Yes		No
Instrumental ADI. Adult	Visual changes (not gla	isses)			
	Dizziness				
<ul> <li>Education Needs</li> </ul>	Double vision				
Healthcare Decision Maker - Amb	Sinus problems				
	Frequent persistent nos	epieeas			
Interpreter Services	Lai pain Trouble bearing				
Review of Systems	Binging in Ears				
Behavioral Pain Score	Hoarseness				
	Persistent sore throat				
FLACC Pain Score	Mouth sores				
NIPS Pain Score	Nasal Drainage				
NDASS Pain Soom	Swollen glands (Freque	nt)			
NEADS FAIL SCORE					



Cerner PowerChart Ambulatory EDUCATION

#### **Education Needs**

Educational Needs is **required** to be completed.

- a. Barriers to Learning is **required** to be documented at every visit.
- b. Patient/Family Learning Style Preferences for the patient and family may be documented. Multiple learning styles can be selected by clicking inside the boxes. These preferences will be saved across visits.
- c. Patient/Family Education Needs Comments is a free text box for any additional comments.

Intake Summary	Education Needs/Learning Style
Detailed Vitals and Measurements	
PHQ-2 and PHQ-9	
Allergies and Medications	Barriers to Learning
Social History	None evident Difficulty concentrating Literacy
Family History	Cognitive deficits     Financial concerns     Vision impairment
Obstetrical History	Cultural barrier E Hearing deficit C Other:
Procedure and Surgical History	Desire/Motivation Language barrier
Problems and Diagnosis	
Infectious Disease Risk Screening	Patient/Family Learning Style Preferences
Psychosocial and Spiritual	None Demonstration Printed materials Verbal explanation Video/Educational TV Comment
Conley Fall Risk Scale	Family
Instrumental ADL Adult	
Education Needs	
Healthcare Decision Maker - Amb	
Interpreter Services	Patient/Family Education Needs Comments
Review of Systems	Segoe UI
Behavioral Pain Score	

#### Signing the Form

When documentation is complete, click the green check on the top of the PowerForm to sign and complete the Medicare Annual Wellness Visit PowerForm.

