

FORM INSTRUCTIONS

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3. The date and location of all source documentation must be entered into the "Comments" section of the Web Interface.
4. Minimize the use of abbreviations wherever possible.

DEMOGRAPHICS

Medicare/Medical Record/Other Patient ID: _____ Clinic ID: _____

First / Last Name: _____ Date of Birth: ___/___/___

PATIENT MEDICAL RECORD

Medical Record Found?	Reason Not Qualified?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not qualified for sample	<input type="checkbox"/> Deceased - as of ___/___/___ <input type="checkbox"/> In hospice - as of ___/___/___ <input type="checkbox"/> HMO Enrollment - as of ___/___/___ <input type="checkbox"/> Moved Out-of-Country - as of ___/___/___

CARE-1: Medication Reconciliation Post-Discharge

RANK: _____

CARE-1 Confirmed
 Yes
 No - Measure-Specific Exclusion: _____
 No - Other CMS-Approved Reason - HelpDesk Ticket # _____

Comments: *

CARE-1 ABSTRACTION DATA

CMS-Provided Visit Date	Patient Seen?	Patient Seen On Date	Were Medications Reconciled?
___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No - Visit Outside Practice	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No - Denominator Exclusion - Medical Reason
___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No - Visit Outside Practice	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No - Denominator Exclusion - Medical Reason
___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No - Visit Outside Practice	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No - Denominator Exclusion - Medical Reason

Comments: *

CARE-2: Falls - Screening for Future Fall Risk

RANK: _____

CARE-2 Confirmed
 Yes
 No - Measure-Specific Exclusion: _____
 No - Other CMS-Approved Reason - HelpDesk Ticket # _____

Comments: *

CARE-2 ABSTRACTION DATA

Screening for Future Fall Risk?	Comments: *
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No - Denominator Exclusion - Medical Reasons	

DM-2: Diabetes - Hemoglobin A1c (HbA1c) Poor Control (>9%) and DM-7: Diabetes - Eye Exam

RANK: _____

DM-2 Confirmed
 Yes
 No - Missing diagnosis of either Type 1 or Type 2 diabetes mellitus
 No - Other CMS-Approved Reason - HelpDesk Ticket # _____

Comments: *

DM-2 ABSTRACTION DATA

HbA1c Test Performed?	Date Drawn	HbA1c Value	Comments: *
<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___	_____	

DM-7 ABSTRACTION DATA

Retinal Exam Performed?	Comments: *
<input type="checkbox"/> Yes <input type="checkbox"/> No	

HTN-2: Controlling High Blood Pressure **RANK:** _____

HTN-2 Confirmed

Yes

No - Missing diagnosis of essential hypertension

No - Measure-Specific Exclusion: _____

No - Other CMS-Approved Reason - HelpDesk Ticket # _____

*Comments: **

HTN-2 ABSTRACTION DATA				
<i>Most Recent BP</i>	<i>Date Taken</i>	<i>Systolic</i>	<i>Diastolic</i>	<i>Comments: *</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___	_____	_____	

IVD-2: Ischemic Vascular Disease (IVD) - Use of Aspirin or Another Antiplatelet **RANK:** _____

IVD-2 Confirmed

Yes

No - Missing diagnosis of AMI, CABG, or PCI between 1/1-12/31/2016

No - Missing active diagnosis of IVD **with** antiplatelet use during MP

No - Measure-Specific Exclusion: _____

No - Other CMS-Approved Reason - HelpDesk Ticket # _____

*Comments: **

IVD-2 ABSTRACTION DATA	
<i>Use of Aspirin/Antithrombotic Therapy?</i>	<i>Comments: *</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	

MH-1: Depression Remission at Twelve Months **RANK:** _____

MH-1 Confirmed

Yes

No - Missing diagnosis of major depression or dysthymia

No - Measure-Specific Exclusion: _____

No - Other CMS-Approved Reason - HelpDesk Ticket # _____

*Comments: **

MH-1 ABSTRACTION DATA		
<i>Index PHQ-9</i>	<i>Follow-Up (FU) PHQ-9</i>	<i>Comments: *</i>
Index PHQ-9 Performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	FU PHQ-9 Performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Index PHQ-9 Date: ___/___/___	FU PHQ-9 Date: ___/___/___	
Index PHQ-9 Test > 9? <input type="checkbox"/> Yes <input type="checkbox"/> No	FU PHQ-9 Test < 5? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Index PHQ-9 Test Score: _____	FU PHQ-9 Test Score: _____	

PREV-5: Breast Cancer Screening **RANK:** _____

PREV-5 Confirmed

Yes

No - Measure-Specific Exclusion: _____

No - Other CMS-Approved Reason - HelpDesk Ticket # _____

*Comments: **

PREV-5 ABSTRACTION DATA	
<i>Screening performed?</i>	<i>Comments: *</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	

PREV-6: Colorectal Cancer Screening **RANK:** _____

PREV-6 Confirmed

Yes

No - Measure-Specific Exclusion: _____

No - Other CMS-Approved Reason - HelpDesk Ticket # _____

*Comments: **

PREV-6 ABSTRACTION DATA	
<i>Screening current?</i>	<i>Comments: *</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	

PREV-7: Influenza Immunization **RANK:** _____

PREV-7 Confirmed

Yes

No - Measure-Specific Exclusion: _____

No - Other CMS-Approved Reason - HelpDesk Ticket # _____

*Comments: **

PREV-7 ABSTRACTION DATA

Immunization Received?

Yes | No

No - Denominator Exclusion - Medical reason

No - Denominator Exclusion - Patient reason

No - Denominator Exclusion - System reason

*Comments: **

PREV-8: Pneumococcal Vaccination Status for Older Adults **RANK:** _____

PREV-8 Confirmed

Yes

No - Measure-Specific Exclusion: _____

No - Other CMS-Approved Reason - HelpDesk Ticket # _____

*Comments: **

PREV-8 ABSTRACTION DATA

Vaccination Received?

Yes | No

*Comments: **

PREV-9: Body Mass Index (BMI) Screening and Follow-Up Plan **RANK:** _____

PREV-9 Confirmed

Yes

No - Measure-Specific Exclusion: _____

No - Other CMS-Approved Reason - HelpDesk Ticket # _____

*Comments: **

PREV-9 ABSTRACTION DATA

Calculated BMI?

Yes | No

No - Denominator Exclusion - Medical reason

No - Denominator Exclusion - Patient reason

BMI Evaluation & Treatment

BMI Normal? Yes No

Follow-Up Plan? Yes No

*Comments: **

PREV-10: Tobacco Use - Screening and Intervention **RANK:** _____

PREV-10 Confirmed

Yes

No - Measure-Specific Exclusion: _____

No - Other CMS-Approved Reason - HelpDesk Ticket # _____

*Comments: **

PREV-10 ABSTRACTION DATA

Tobacco Use

Yes | No

No - Unscreened / Unknown

No - Denominator Exclusion - Medical reason

Cessation Counseling Intervention

Yes No

*Comments: **

PREV-12: Screening for Depression and Follow-Up Plan **RANK:** _____

PREV-12 Confirmed

Yes

No - Measure-Specific Exclusion: _____

No - Other CMS-Approved Reason - HelpDesk Ticket # _____

*Comments: **

PREV-12 ABSTRACTION DATA

Clinical Depression Screening Performed?

Yes | No

No - Denominator Exclusion - Medical reason

No - Denominator Exclusion - Patient reason

Depression Screening Outcome & Follow-Up (FU)

Positive Screen? Yes No

Follow-Up Plan? Yes No

*Comments: **

PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

RANK:

PREV-13 Confirmed

Comments: *

- Yes
- No - Missing active diagnosis of ASCVD
- No - No LDL-C \geq 190 mg/dL on chart
- No - No diagnosis of familial / pure hypercholesterolemia on chart
- No - No diagnosis of Type 1 or Type 2 diabetes mellitus with a fasting or direct LDL-C of 70-189 mg/dL recorded as highest result from 01/01/2015 - 12/31/2017
- No - Measure-Specific Exclusion: _____
- No - Other CMS-Approved Reason - HelpDesk Ticket # _____

PREV-13 ABSTRACTION DATA

- | | | |
|---------------------------|------------------------------|-----------------------------|
| LDL-C \geq 190 mg/dl? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Type 1 or 2 Diabetes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| LDL-C 70-189 mg/dl? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Prescribed/Taking Statin? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Comments: *

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DEMOGRAPHICS

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 First / Last Name: _____ Date of Birth: ___/___/___

PATIENT MEDICAL RECORD

Medical Record Found?	Reason Not Qualified?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not qualified for sample	<input type="checkbox"/> Deceased - as of ___/___/___ <input type="checkbox"/> In hospice - as of ___/___/___ <input type="checkbox"/> HMO Enrollment - as of ___/___/___ <input type="checkbox"/> Moved Out-of-Country - as of ___/___/___

CARE-1: Medication Reconciliation Post-Discharge

RANK: _____

CARE-1 Confirmed
 Yes
 No - Measure-Specific Exclusion: _____
 No - Other CMS-Approved Reason - HelpDesk Ticket # _____

Comments: *

CARE-1 ABSTRACTION DATA

CMS-Provided Visit Date	Patient Seen?	Patient Seen On Date	Were Medications Reconciled?
___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No - Visit Outside Practice	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No - Denominator Exclusion - Medical Reason
___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No - Visit Outside Practice	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No - Denominator Exclusion - Medical Reason
___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No - Visit Outside Practice	___/___/___	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No - Denominator Exclusion - Medical Reason

Comments: *

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Medicare/Medical Record/Other Patient ID: _____ Clinic ID: _____
 First / Last Name: _____ Date of Birth: ___/___/___

PATIENT MEDICAL RECORD

Medical Record Found?	Reason Not Qualified?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not qualified for sample	<input type="checkbox"/> Deceased - as of ___/___/___ <input type="checkbox"/> In hospice - as of ___/___/___	<input type="checkbox"/> HMO Enrollment - as of ___/___/___ <input type="checkbox"/> Moved Out-of-Country - as of ___/___/___

CARE-2: Falls - Screening for Future Fall Risk

RANK: _____

CARE-2 Confirmed

Yes

No - Measure-Specific Exclusion: _____

No - Other CMS-Approved Reason - HelpDesk Ticket # _____

Comments: *

CARE-2 ABSTRACTION DATA

Screening for Future Fall Risk?	Comments: *
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No - Denominator Exclusion - Medical Reasons	

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Medicare/Medical Record/Other Patient ID: _____ Clinic ID: _____
 First / Last Name: _____ Date of Birth: ___/___/___

PATIENT MEDICAL RECORD

Medical Record Found?	Reason Not Qualified?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not qualified for sample	<input type="checkbox"/> Deceased - as of ___/___/___ <input type="checkbox"/> In hospice - as of ___/___/___	<input type="checkbox"/> HMO Enrollment - as of ___/___/___ <input type="checkbox"/> Moved Out-of-Country - as of ___/___/___

DM-2: Diabetes - Hemoglobin A1c (HbA1c) Poor Control (>9%) and DM-7: Diabetes - Eye Exam **RANK:** _____

DM-2 Confirmed <input type="checkbox"/> Yes <input type="checkbox"/> No - Missing diagnosis of either Type 1 or Type 2 diabetes mellitus <input type="checkbox"/> No - Other CMS-Approved Reason - HelpDesk Ticket # _____	Comments: *
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DM-2 ABSTRACTION DATA

HbA1c Test Performed?	Date Drawn	HbA1c Value	Comments: *
<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___	_____	

DM-7 ABSTRACTION DATA

Retinal Exam Performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: *
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Medicare/Medical Record/Other Patient ID: _____ Clinic ID: _____
 First / Last Name: _____ Date of Birth: ___/___/___

PATIENT MEDICAL RECORD

Medical Record Found?	Reason Not Qualified?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not qualified for sample	<input type="checkbox"/> Deceased - as of ___/___/___ <input type="checkbox"/> In hospice - as of ___/___/___	<input type="checkbox"/> HMO Enrollment - as of ___/___/___ <input type="checkbox"/> Moved Out-of-Country - as of ___/___/___

HTN-2: Controlling High Blood Pressure

RANK: _____

HTN-2 Confirmed

Yes
 No - Missing diagnosis of essential hypertension
 No - Measure-Specific Exclusion: _____
 No - Other CMS-Approved Reason - HelpDesk Ticket # _____

Comments: *

HTN-2 ABSTRACTION DATA

Most Recent BP	Date Taken	Systolic	Diastolic	Comments: *
<input type="checkbox"/> Yes <input type="checkbox"/> No	___/___/___	_____	_____	

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Medicare/Medical Record/Other Patient ID: _____ Clinic ID: _____
 First / Last Name: _____ Date of Birth: ____/____/____

PATIENT MEDICAL RECORD

<i>Medical Record Found?</i>	<i>Reason Not Qualified?</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not qualified for sample	<input type="checkbox"/> Deceased - as of ____/____/____ <input type="checkbox"/> In hospice - as of ____/____/____	<input type="checkbox"/> HMO Enrollment - as of ____/____/____ <input type="checkbox"/> Moved Out-of-Country - as of ____/____/____

IVD-2: Ischemic Vascular Disease (IVD) - Use of Aspirin or Another Antiplatelet RANK: _____

<p><i>IVD-2 Confirmed</i></p> <input type="checkbox"/> Yes <input type="checkbox"/> No - Missing diagnosis of AMI, CABG, or PCI between 1/1-12/31/2016 <input type="checkbox"/> No - Missing active diagnosis of IVD with antiplatelet use during MP <input type="checkbox"/> No - Measure-Specific Exclusion: _____ <input type="checkbox"/> No - Other CMS-Approved Reason - HelpDesk Ticket # _____	<p>Comments: *</p>
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IVD-2 ABSTRACTION DATA

<p><i>Use of Aspirin/Antithrombotic Therapy?</i></p> <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Comments: *</p>
---	---------------------------

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DEMOGRAPHICS

Medicare/Medical Record/Other Patient ID: _____ Clinic ID: _____
 First / Last Name: _____ Date of Birth: ____/____/____

PATIENT MEDICAL RECORD

Medical Record Found?	Reason Not Qualified?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not qualified for sample	<input type="checkbox"/> Deceased - as of ____/____/____ <input type="checkbox"/> In hospice - as of ____/____/____	<input type="checkbox"/> HMO Enrollment - as of ____/____/____ <input type="checkbox"/> Moved Out-of-Country - as of ____/____/____

MH-1: Depression Remission at Twelve Months

RANK: _____

MH-1 Confirmed

Yes
 No - Missing diagnosis of major depression or dysthymia
 No - Measure-Specific Exclusion: _____
 No - Other CMS-Approved Reason - HelpDesk Ticket # _____

Comments: *

MH-1 ABSTRACTION DATA

<u>Index PHQ-9</u>	<u>Follow-Up (FU) PHQ-9</u>	Comments: *
Index PHQ-9 Performed? <input type="checkbox"/> Yes <input type="checkbox"/> No Index PHQ-9 Date: ____/____/____ Index PHQ-9 Test > 9? <input type="checkbox"/> Yes <input type="checkbox"/> No Index PHQ-9 Test Score: _____	FU PHQ-9 Performed? <input type="checkbox"/> Yes <input type="checkbox"/> No FU PHQ-9 Date: ____/____/____ FU PHQ-9 Test < 5? <input type="checkbox"/> Yes <input type="checkbox"/> No FU PHQ-9 Test Score: _____	

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DEMOGRAPHICS

Medicare/Medical Record/Other Patient ID: _____ Clinic ID: _____
 First / Last Name: _____ Date of Birth: ____/____/____

PATIENT MEDICAL RECORD

<i>Medical Record Found?</i>	<i>Reason Not Qualified?</i>	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not qualified for sample	<input type="checkbox"/> Deceased - as of ____/____/____ <input type="checkbox"/> In hospice - as of ____/____/____	<input type="checkbox"/> HMO Enrollment - as of ____/____/____ <input type="checkbox"/> Moved Out-of-Country - as of ____/____/____

PREV-5: Breast Cancer Screening

RANK: _____

PREV-5 Confirmed

Yes

No - Measure-Specific Exclusion: _____

No - Other CMS-Approved Reason - HelpDesk Ticket # _____

Comments: *

PREV-5 ABSTRACTION DATA

<i>Screening performed?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments: *
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DEMOGRAPHICS

Medicare/Medical Record/Other Patient ID: _____ Clinic ID: _____
 First / Last Name: _____ Date of Birth: ___/___/___

PATIENT MEDICAL RECORD

Medical Record Found?	Reason Not Qualified?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not qualified for sample	<input type="checkbox"/> Deceased - as of ___/___/___ <input type="checkbox"/> In hospice - as of ___/___/___	<input type="checkbox"/> HMO Enrollment - as of ___/___/___ <input type="checkbox"/> Moved Out-of-Country - as of ___/___/___

PREV-6: Colorectal Cancer Screening

RANK: _____

PREV-6 Confirmed

Yes
 No - Measure-Specific Exclusion: _____
 No - Other CMS-Approved Reason - HelpDesk Ticket # _____

Comments: *

PREV-6 ABSTRACTION DATA

Screening current?	Comments: *
<input type="checkbox"/> Yes <input type="checkbox"/> No	

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DEMOGRAPHICS

Medicare/Medical Record/Other Patient ID: _____ Clinic ID: _____
 First / Last Name: _____ Date of Birth: ____/____/____

PATIENT MEDICAL RECORD

Medical Record Found?	Reason Not Qualified?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not qualified for sample	<input type="checkbox"/> Deceased - as of ____/____/____ <input type="checkbox"/> HMO Enrollment - as of ____/____/____ <input type="checkbox"/> In hospice - as of ____/____/____ <input type="checkbox"/> Moved Out-of-Country - as of ____/____/____

PREV-7: Influenza Immunization

RANK: _____

PREV-7 Confirmed

Yes
 No - Measure-Specific Exclusion: _____
 No - Other CMS-Approved Reason - HelpDesk Ticket # _____

Comments: *

PREV-7 ABSTRACTION DATA

Immunization Received?

Yes | No
 No - Denominator Exclusion - Medical reason
 No - Denominator Exclusion - Patient reason
 No - Denominator Exclusion - System reason

Comments: *

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DEMOGRAPHICS

Medicare/Medical Record/Other Patient ID: _____ Clinic ID: _____

First / Last Name: _____ Date of Birth: ____/____/____

PATIENT MEDICAL RECORD

Medical Record Found?	Reason Not Qualified?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not qualified for sample	<input type="checkbox"/> Deceased - as of ____/____/____ <input type="checkbox"/> In hospice - as of ____/____/____	<input type="checkbox"/> HMO Enrollment - as of ____/____/____ <input type="checkbox"/> Moved Out-of-Country - as of ____/____/____

PREV-8: Pneumococcal Vaccination Status for Older Adults

RANK: _____

PREV-8 Confirmed

Yes
 No - Measure-Specific Exclusion: _____
 No - Other CMS-Approved Reason - HelpDesk Ticket # _____

Comments: *

PREV-8 ABSTRACTION DATA

Vaccination Received?	Comments: *
<input type="checkbox"/> Yes <input type="checkbox"/> No	

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DEMOGRAPHICS

Medicare/Medical Record/Other Patient ID: _____ Clinic ID: _____
 First / Last Name: _____ Date of Birth: ___/___/___

PATIENT MEDICAL RECORD

Medical Record Found?	Reason Not Qualified?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not qualified for sample	<input type="checkbox"/> Deceased - as of ___/___/___ <input type="checkbox"/> In hospice - as of ___/___/___	<input type="checkbox"/> HMO Enrollment - as of ___/___/___ <input type="checkbox"/> Moved Out-of-Country - as of ___/___/___

PREV-9: Body Mass Index (BMI) Screening and Follow-Up Plan

RANK: _____

PREV-9 Confirmed

Yes
 No - Measure-Specific Exclusion: _____
 No - Other CMS-Approved Reason - HelpDesk Ticket # _____

Comments: *

PREV-9 ABSTRACTION DATA

Calculated BMI?	BMI Evaluation & Treatment	Comments: *
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No - Denominator Exclusion - Medical reason <input type="checkbox"/> No - Denominator Exclusion - Patient reason	BMI Normal? <input type="checkbox"/> Yes <input type="checkbox"/> No Follow-Up Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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DEMOGRAPHICS

Medicare/Medical Record/Other Patient ID: _____ Clinic ID: _____

First / Last Name: _____ Date of Birth: ____/____/____

PATIENT MEDICAL RECORD

Medical Record Found?	Reason Not Qualified?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not qualified for sample	<input type="checkbox"/> Deceased - as of ____/____/____ <input type="checkbox"/> In hospice - as of ____/____/____	<input type="checkbox"/> HMO Enrollment - as of ____/____/____ <input type="checkbox"/> Moved Out-of-Country - as of ____/____/____

PREV-10: Tobacco Use - Screening and Intervention

RANK: _____

PREV-10 Confirmed

Yes
 No - Measure-Specific Exclusion: _____
 No - Other CMS-Approved Reason - HelpDesk Ticket # _____

Comments: *

PREV-10 ABSTRACTION DATA

Tobacco Use	Cessation Counseling Intervention	Comments: *
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No - Unscreened / Unknown <input type="checkbox"/> No - Denominator Exclusion - Medical reason	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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DEMOGRAPHICS

Medicare/Medical Record/Other Patient ID: _____ Clinic ID: _____

First / Last Name: _____ Date of Birth: ___/___/___

PATIENT MEDICAL RECORD

Medical Record Found?	Reason Not Qualified?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not qualified for sample	<input type="checkbox"/> Deceased - as of ___/___/___ <input type="checkbox"/> In hospice - as of ___/___/___	<input type="checkbox"/> HMO Enrollment - as of ___/___/___ <input type="checkbox"/> Moved Out-of-Country - as of ___/___/___

PREV-12: Screening for Depression and Follow-Up Plan

RANK: _____

PREV-12 Confirmed

Yes
 No - Measure-Specific Exclusion: _____
 No - Other CMS-Approved Reason - HelpDesk Ticket # _____

Comments: *

PREV-12 ABSTRACTION DATA

Clinical Depression Screening Performed?	Depression Screening Outcome & Follow-Up (FU)	Comments: *
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> No - Denominator Exclusion - Medical reason <input type="checkbox"/> No - Denominator Exclusion - Patient reason	Positive Screen? <input type="checkbox"/> Yes <input type="checkbox"/> No Follow-Up Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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DEMOGRAPHICS

Medicare/Medical Record/Other Patient ID: _____ Clinic ID: _____
 First / Last Name: _____ Date of Birth: ____/____/____

PATIENT MEDICAL RECORD

Medical Record Found?	Reason Not Qualified?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not qualified for sample	<input type="checkbox"/> Deceased - as of ____/____/____ <input type="checkbox"/> In hospice - as of ____/____/____	<input type="checkbox"/> HMO Enrollment - as of ____/____/____ <input type="checkbox"/> Moved Out-of-Country - as of ____/____/____

PREV-13: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

RANK: _____

PREV-13 Confirmed

Yes
 No - Missing active diagnosis of ASCVD
 No - No LDL-C \geq 190 mg/dL on chart
 No - No diagnosis of familial / pure hypercholesterolemia on chart
 No - No diagnosis of Type 1 or Type 2 diabetes mellitus with a fasting or direct LDL-C of 70-189 mg/dL recorded as highest result from 01/01/2015 - 12/31/2017
 No - Measure-Specific Exclusion: _____
 No - Other CMS-Approved Reason - HelpDesk Ticket # _____

Comments: *

PREV-13 ABSTRACTION DATA

LDL-C \geq 190 mg/dl?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Comments: *
Type 1 or 2 Diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
LDL-C 70-189 mg/dl?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Prescribed/Taking Statin?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	