



# Health Risk 360

## How to Complete the HR360

Use one of the following methods to complete this form:

- ▶ Use our interactive AutoHR360 tool for easier submission. Log in to **myBlue Provider** and click Blue Advantage Resources. You will find the HR360 link under Provider Tools at the top of the webpage.
- ▶ You have the option to print a blank form and upload it through the AutoHR360 tool if that works best with your workflow.

## Tips for completing the HR360:

- ▶ Complete all pages and sections of the HR360 form. **Incomplete forms will not be accepted.**
- ▶ Verify patient information (patient name, Patrius Health subscriber number, date of birth and date of service) is visible on each page.
- ▶ Document vital signs for in-office visits.
- ▶ After the claim for the AWW or physical exam is adjudicated, you will receive a medical record request under myNotifications in myBlue Provider. Use that notification to upload the completed HR360 form. **Telehealth encounters performed via audio only are not eligible for the HR360 incentive.**
- ▶ Include the provider name, tax ID, and NPI number.
- ▶ Verify that the provider's signature and credentials are legible.

**Note:** For additional information, review the Patrius Health provider website for details.

Patient Name:	DOB:	DOS:	Contract Number:	NPI#:
---------------	------	------	------------------	-------

# Health Risk 360



PCP:	BP#1 /	BP#2 /	if BP ≥ 140/90 Repeat
------	--------	--------	-----------------------

Height:	Feet	Inches	Weight:	LBS	<input type="checkbox"/> Unable to obtain	BMI:	Morbid Obesity:	<input type="checkbox"/> Yes <input type="checkbox"/> No
---------	------	--------	---------	-----	---	------	-----------------	--

**Assessment was Telehealth**  Audio and Video (Note: If Audio Only - Do Not Submit Form)

**Note:** In each section below, please document and include all current, chronic, and historical conditions affecting the care, treatment, or management of your patient, noting all manifestations and sequelae.

**Preventive Care**

Mammogram DOS:	Bone Density/Dexa DOS:
Vaccines:	Colon Cancer:
<input type="checkbox"/> Pneumonia Date: _____	<input type="checkbox"/> Colonoscopy DOS: _____
<input type="checkbox"/> Flu Date: _____	<input type="checkbox"/> Flex Sig DOS: _____
<input type="checkbox"/> COVID-19 (Most Recent) Date: _____ <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Booster <input type="checkbox"/> Patient Refused	<input type="checkbox"/> FitDNA (e.g., Cologuard) DOS: _____
	<input type="checkbox"/> FOBT/gFOBT/FIT DOS: _____

**Medication (List Below or Attach Active Rx List)**

<input type="checkbox"/> Statin Intolerance Due to:	<input type="checkbox"/> Med Adherence Issues:
Inpt D/C in last 31 days: <input type="checkbox"/> Yes D/C Date:	Inpt Rx Reconciled: <input type="checkbox"/> No <input type="checkbox"/> Yes (Bill Code: 1111F)

*In the following section, attach the medication list, or complete in the space provided.*

Active Rx List:  Attached (Current/Signed/Dated)

1.	13.
2.	14.
3.	15.
4.	16.
5.	17.
6.	18.
7.	19.
8.	20.
9.	21.
10.	22.
11.	23.
12.	24.

**Surgical History**  Reviewed and not applicable

<input type="checkbox"/> Organ Transplant: Type + Year:	<input type="checkbox"/> CABG Date(s):	<input type="checkbox"/> PTCA Date(s):
<input type="checkbox"/> Mastectomy:	<input type="checkbox"/> AICD Date(s):	
<input type="checkbox"/> Bilat. Date: <input type="checkbox"/> Unilat. <input type="checkbox"/> L <input type="checkbox"/> R Date:	<input type="checkbox"/> Other Ostomy (list site and date):	
<input type="checkbox"/> Colostomy Date: <input type="checkbox"/> Tot. Colectomy Date:		

**Hypertension**  Reviewed and not applicable

<input type="checkbox"/> Essential Hypertension	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Hypertension w/CKD (stage):	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Hypertension w/Heart Failure:	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Hypertension w/Heart Failure + CKD (Stage):	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Portal Hypertension	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Pulmonary Hypertension	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Venous Hypertension w/Ulcer, Chronic	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> HTN w/Other Complications:	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist

Patient Name:	DOB:	DOS:
---------------	------	------

**Nutritional/Metabolic**  Reviewed and not applicable

<input type="checkbox"/> Hyperlipidemia Due to diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Mixed Hyperlipidemia	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Cachexia	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Malnutrition	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Anorexia Nervosa <input type="checkbox"/> Bulimia Nervosa	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Other Nutritional/Metabolic Condition:	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist

**Cardiovascular**  Reviewed and not applicable

<input type="checkbox"/> Unstable Angina <input type="checkbox"/> Postinfarction Angina	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Acute Ischemic Heart Disease	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Myocardial Infarction <input type="checkbox"/> In last 4 weeks	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Heart Failure <input type="checkbox"/> End Stage <input type="checkbox"/> Acute on Chronic <input type="checkbox"/> Acute or AoC RHF <input type="checkbox"/> Chronic/Unspecified	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Aneurysm of Pulmonary Artery	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Aortic Aneurysm, Ruptured	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Thromboembolism - aorta or kidney	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Atherosclerosis of Extremities with Gangrene	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Atrial Flutter <input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> DVT: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Upper <input type="checkbox"/> Lower <input type="checkbox"/> Upper and Lower	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Chronic Pulmonary Embolism	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> H/O CVA <input type="checkbox"/> w/ Late Effects:	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Other Cardiovascular Condition:	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist

**Diabetes**  Reviewed and not applicable

<input type="checkbox"/> Diabetes Mellitus: <input type="checkbox"/> Type I <input type="checkbox"/> Type II	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> DM w/Retinopathy <input type="checkbox"/> w/Macular Edema	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> DM w/Cataracts <input type="checkbox"/> DM-related Glaucoma	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> DM w/Hypoglycemia <input type="checkbox"/> DM w/Hyperglycemia	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> DM w/ Diabetic Dermatitis	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> DM w/Gastroparesis	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> DM w/Nephropathy	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> DM w/CKD Stage:	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> DM w/Neuropathy	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> DM w/Arthropathy	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> DM w/ Foot Ulcer	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> DM w/ <input type="checkbox"/> PAD <input type="checkbox"/> PVD <input type="checkbox"/> w/Gangrene	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Other DM-related Complication	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Treating w/ <input type="checkbox"/> Insulin <input type="checkbox"/> Oral Rx <input type="checkbox"/> ACE/ARB <input type="checkbox"/> Statin <input type="checkbox"/> Non-Insulin Inj.	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist

**Ophthalmic**  Reviewed and not applicable

<input type="checkbox"/> Legal Blindness	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Other Ophthalmic Condition:	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist

**Renal**  Reviewed and not applicable

<input type="checkbox"/> CKD 1 (GFR >89) <input type="checkbox"/> CKD 2 (GFR 60-89) <input type="checkbox"/> CKD 3A (GFR 45-59) <input type="checkbox"/> CKD 3B (GFR 30-44) <input type="checkbox"/> CKD 3, unspecified <input type="checkbox"/> CKD 4 (GFR 15-29) <input type="checkbox"/> CKD 5 (GFR <15)	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Chronic Renal Insufficiency	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> ESRD <input type="checkbox"/> Dialysis Status <input type="checkbox"/> AV Shunt for Dialysis Present	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Other Renal:	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist

Patient Name:	DOB:	DOS:
---------------	------	------

**Psychiatric and Substance Abuse**  Reviewed and not applicable

<input type="checkbox"/> Major Depressive Disorder: <input type="checkbox"/> Single or <input type="checkbox"/> Recurrent Severity: <input type="checkbox"/> Mild <input type="checkbox"/> Mod <input type="checkbox"/> Severe <input type="checkbox"/> In Remission <input type="checkbox"/> Unspecified	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Delusional Disorder	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Schizophrenia <input type="checkbox"/> Schizoaffective Disorder	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Other Psychiatric Condition:	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Tobacco Use <input type="checkbox"/> H/O Tobacco Use	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
Alcohol   Cannabis   Cocaine   Opioid   Sedative, Hypnotic or Anxiolytic	
*For any above substance, please complete the Substance Abuse Supplemental on page 5.	

**Dementia**  Reviewed and not applicable

<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Dementia: <input type="checkbox"/> Mild <input type="checkbox"/> Mod <input type="checkbox"/> Severe <input type="checkbox"/> Unspecified	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Vascular Dementia: <input type="checkbox"/> Mild <input type="checkbox"/> Mod <input type="checkbox"/> Severe <input type="checkbox"/> Unspecified	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Neurocognitive Disorders w/Lewy Bodies	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Other Dementia Condition:	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist

**Neurologic**  Reviewed and not applicable

<input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS)	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Monoplegia <input type="checkbox"/> Paraplegia <input type="checkbox"/> Quadriplegia	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Multiple Sclerosis (MS) <input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Acute Exacerbation? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> w/Dementia	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Parkinsonism	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Other Neurologic Condition:	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist

**Musculoskeletal and Skin**  Reviewed and not applicable

<input type="checkbox"/> Amputation, H/O <input type="checkbox"/> Above Knee <input type="checkbox"/> Below Knee <input type="checkbox"/> Ankle <input type="checkbox"/> Foot	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Phantom Limb Syndrome	
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Degenerative Disc Disease	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Systemic Lupus Erythematosus	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Osteomyelitis	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Osteoporosis <input type="checkbox"/> Osteopenia	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Psoriasis <input type="checkbox"/> Psoriatic Arthritis	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Sjogren (Sicca) Syndrome <input type="checkbox"/> w/Lung involvement	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Ulcer, Chronic: <input type="checkbox"/> Non-Pressure <input type="checkbox"/> Pressure (Stage/Site/Severity): _____	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Other Musculoskeletal/Skin Condition:	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist

**GI/GU**  Reviewed and not applicable

<input type="checkbox"/> Ulcerative Colitis (UC) <input type="checkbox"/> w/ Intestinal Obstruction	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Colon Polyps, History Of	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> GERD <input type="checkbox"/> with Esophagitis	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Esophageal Varices <input type="checkbox"/> with Bleeding <input type="checkbox"/> Secondary	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Hepatitis, Chronic Type: _____ Treatment Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Hepatic Failure, Chronic <input type="checkbox"/> Hepatic Encephalopathy	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Alcoholic Hepatitis <input type="checkbox"/> Alcoholic Cirrhosis of Liver <input type="checkbox"/> Alcoholic Hepatic Failure	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Biliary Cirrhosis	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Cirrhosis of Liver	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Incontinence <input type="checkbox"/> Urinary <input type="checkbox"/> Fecal	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist

Patient Name:	DOB:	DOS:
---------------	------	------

<input type="checkbox"/> Benign prostatic hyperplasia (BPH)	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Urinary Catheter	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Other GI/GU Condition:	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist

**Neoplasms**  Reviewed and not applicable

<input type="checkbox"/> Active Cancer Site(s): Site 1 _____ Site 2 _____ Site 3 _____	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Metastasis Site(s): Site 1 _____ Site 2 _____ Site 3 _____	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
Tx: <input type="checkbox"/> Chemo <input type="checkbox"/> Rad Tx <input type="checkbox"/> Tx Completed <input type="checkbox"/> Tx Refused <input type="checkbox"/> No Tx <input type="checkbox"/> In Remission	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist

**Respiratory**  Reviewed and not applicable

<input type="checkbox"/> Asbestosis <input type="checkbox"/> Black Lung <input type="checkbox"/> Pulmonary Fibrosis	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Severe Persistent Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Emphysema <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> Bronchitis, Chronic	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> O2 Dependence, Chronic <input type="checkbox"/> w/Respiratory Failure <input type="checkbox"/> w/o Respiratory Failure	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Dependent on Respirator [ventilator] <input type="checkbox"/> Tracheostomy Present	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Smokers Cough <input type="checkbox"/> Current Tobacco Use <input type="checkbox"/> H/O Smoking	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist
<input type="checkbox"/> Other Respiratory Condition:	<input type="checkbox"/> Rx <input type="checkbox"/> Monitor <input type="checkbox"/> Counsel <input type="checkbox"/> Refer to Specialist

**Health Outcomes - Health Professional to Address and Provide Counseling**  Per Patient Report  Per Caregiver

H/O Falls: <input type="checkbox"/> Yes <input type="checkbox"/> No Afraid of falls: <input type="checkbox"/> Yes <input type="checkbox"/> No
Assistive Device Dependence: <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair <input type="checkbox"/> Independent with ADLs
Fall Risk: <input type="checkbox"/> High <input type="checkbox"/> Med <input type="checkbox"/> Low <input type="checkbox"/> Counseled how to prevent falls or improve balance: <input type="checkbox"/> Yes <input type="checkbox"/> No
Advance Directive: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Counseled Pain: (0-10): _____ <input type="checkbox"/> Changes in Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No

**Depression Screening: PHQ - 2 In the last 2 weeks, how often have you been bothered by any of the following problems:**

1: Little interest or pleasure in doing things: <input type="checkbox"/> Not at All <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
2: Feeling down, depressed or hopeless: <input type="checkbox"/> Not at All <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day

**Blue Advantage Care Coordination/Management Referral**

Indicate referral reason below	Member Phone #: _____	(If changed < 2 years)
<input type="checkbox"/> Rx Assistance <input type="checkbox"/> PharmD review for formulary alternatives <input type="checkbox"/> Patient Education <input type="checkbox"/> CAD <input type="checkbox"/> CHF <input type="checkbox"/> COPD <input type="checkbox"/> Diabetes <input type="checkbox"/> MI <input type="checkbox"/> Other: _____	Social Concerns: <input type="checkbox"/> Transportation <input type="checkbox"/> Food Insecurity <input type="checkbox"/> Housing Insecurity <input type="checkbox"/> Isolation <input type="checkbox"/> Other: _____	

**Substance Abuse – Supplemental**

<input type="checkbox"/> Alcohol	<input type="checkbox"/> Use <input type="checkbox"/> Dependence <input type="checkbox"/> Abuse	<input type="checkbox"/> w/ Delirium, Dementia, Psychotic Disorder <input type="checkbox"/> w/ Withdrawal, Mood/Sleep/Sex Disorder <input type="checkbox"/> Uncomplicated <input type="checkbox"/> w/ Delirium, Dementia, Psychotic Disorder <input type="checkbox"/> w/ Withdrawal, Mood/Sleep/Sex Disorder <input type="checkbox"/> Uncomplicated <input type="checkbox"/> w/ Delirium, Dementia, Psychotic Disorder <input type="checkbox"/> w/ Withdrawal, Mood/Sleep/Sex Disorder
<input type="checkbox"/> Opioid	<input type="checkbox"/> Use <input type="checkbox"/> Dependence <input type="checkbox"/> Abuse	<input type="checkbox"/> w/ Delusions, Hallucinations, Psychotic Disorder <input type="checkbox"/> w/ Intoxication, Withdrawal, Mood/Sleep/Sex Disorder <input type="checkbox"/> w/ Delusions, Hallucinations, Psychotic Disorder <input type="checkbox"/> w/ Intoxication, Withdrawal, Mood/Sleep/Sex Disorder <input type="checkbox"/> Uncomplicated <input type="checkbox"/> w/ Delusions, Hallucinations, Psychotic Disorder <input type="checkbox"/> w/ Intoxication, Withdrawal, Mood/Sleep/Sex Disorder
<input type="checkbox"/> Cannabis	<input type="checkbox"/> Use <input type="checkbox"/> Dependence <input type="checkbox"/> Abuse	<input type="checkbox"/> w/ Delusions, Hallucinations, Psychotic Disorder <input type="checkbox"/> w/ Withdrawal, Anxiety Disorder <input type="checkbox"/> Uncomplicated, In Remission <input type="checkbox"/> w/ Delusions, Hallucinations, Psychotic Disorder <input type="checkbox"/> w/ Withdrawal, Anxiety Disorder <input type="checkbox"/> w/ Delusions, Hallucinations, Psychotic Disorder <input type="checkbox"/> w/ Withdrawal, Anxiety Disorder
<input type="checkbox"/> Cocaine	<input type="checkbox"/> Use <input type="checkbox"/> Dependence <input type="checkbox"/> Abuse	<input type="checkbox"/> w/ Delusions, Hallucinations, Psychotic Disorder <input type="checkbox"/> w/ Intoxication, Withdrawal, Mood/Sleep/Sex Disorder <input type="checkbox"/> w/ Delusions, Hallucinations, Psychotic Disorder <input type="checkbox"/> w/ Intoxication, Withdrawal, Mood/Sleep/Sex Disorder <input type="checkbox"/> Uncomplicated <input type="checkbox"/> w/ Delusions, Hallucinations, Psychotic Disorder <input type="checkbox"/> w/ Intoxication, Withdrawal, Mood/Sleep/Sex Disorder

Patient Name:	DOB:	DOS:
---------------	------	------

I have reviewed and recommended the age and gender specific screenings and care plans with my patient. All diagnoses assessed herein affect the care, treatment, or management of my patient.

Examiner's Name (Print):	NPI#	
Examiner's Signature:	Credential	Date:
	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> NP <input type="checkbox"/> PA	

**Completed HR360 forms must be signed and dated by the examining practitioner to be considered valid.**



Blue Advantage® PPO is provided by Patrius Health, an independent licensee of the Blue Cross and Blue Shield Association.