Affiliated Partners
Independent Physician Association

Care of Older Adults (COA)
Assessment Form

MEMBER		
Last Name:	First Name:	
DOB:	Service Date:	Blood Pressure:
Height:	Weight:	BMI:

Advanced Care Planning Discussed: Yes ____ No ____

PAIN ASSESSMENT CPT II: 1125F, 1126F
Pain Assessed: Yes____ No ____ ***(required)***
Notes:

FUNCTIONAL ASSESSMENT CPT II: 1170F
ADLs – Activities of Daily Living Assessed: Yes ____ No ____ ***(required)***
Needs Assistance (circle): Dressing Bathing Toileting Walking Eating
Notes:

MEDICATION REVIEW CPT II (must use both): 1159F AND 1160F	
Patient has no medications: __ *(check if applicable)*	
List comprehensive current medications and dosage. Add pages as needed Signature below acknowledges review.	

_____ _____

Provider Name **Credentials** **Provider Signature**