Sussex County Transitional Care Program

Personal Health Record of __________________________ (Name)

If you have questions or concerns, contact __________________
at (____) _____ - __________

REMEMBER to take this record with you to all doctor visits

<table>
<thead>
<tr>
<th>Service name</th>
<th>Who is covered</th>
<th>How often</th>
<th>Date completed</th>
<th>Next appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome to Medicare Preventive</td>
<td>All Medicare patients</td>
<td>Once within first 12 months of Part B coverage</td>
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<tr>
<td>physical exam</td>
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<tr>
<td>Annual Wellness Visit (AWV)</td>
<td>All Medicare patients</td>
<td>Annually (every 12 months)</td>
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<tr>
<td>Bone Mass Measurement</td>
<td>Medicare patients at risk for osteoporosis</td>
<td>Every 24 months (more if needed)</td>
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<tr>
<td>Cardiovascular Disease Screening</td>
<td>All asymptomatic Medicare patients</td>
<td>Every 5 years</td>
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<tr>
<td>Colon Cancer Screening</td>
<td>All Medicare patients</td>
<td>Every 10 years (unless high risk)</td>
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<td></td>
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<tr>
<td>Service name</td>
<td>Who is covered</td>
<td>How often</td>
<td>Date completed</td>
<td>Next appointment</td>
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<tr>
<td>Diabetes screening</td>
<td>Medicare patients with certain risk factors</td>
<td>2 screening tests per year for those with pre-diabetes; 1 if not diagnosed or never tested</td>
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<tr>
<td>Glaucoma screening</td>
<td>Medicare patients with certain risk factors</td>
<td>Annually for those in high risk group</td>
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<td>Pneumonia vaccine</td>
<td>All Medicare patients</td>
<td>Once in a lifetime, unless high risk</td>
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<tr>
<td>Flu vaccine</td>
<td>All Medicare patients</td>
<td>Once per flu season (fall or winter) or as needed</td>
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<tr>
<td>Prostate Cancer Screening</td>
<td>All male Medicare patients over 50</td>
<td>Once every 12 months</td>
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<td>Screening mammography</td>
<td>All female Medicare patients over 40</td>
<td>Annually</td>
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Personal Information

Family Caregiver Information
Name: ____________________________
Relation to Patient: _________________________
Phone #: ____________________________
Alternate Phone #: ________________________
In what ways do your caregivers help you manage your conditions?
______________________________
______________________________

Advance Directive/Living Will:
☐ No   ☐ Yes Where can this be found?
______________________________

Health Care Provider Information
Primary Care Dr.: ________________________
Phone #: ________________________
Pharmacy: ________________________
Other Providers: ________________________

Questions for other Providers:

Pharmacist: ________________________
Case Manager: ________________________
Other (list name, specialty, organization): ________________________
Questions for Primary Care

Doctor:

My Health Conditions: (Doctor completes)

1. 
   Red Flags: 
   Action Steps: 

2. 
   Red Flags: 
   Action Steps: 

3. 
   Red Flags: 
   Action Steps: 

4. 
   Red Flags: 
   Action Steps: 

5. 
   Red Flags: 
   Action Steps: 

Allergies

Medication
Record
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<th>Name</th>
<th>Dose</th>
<th>How Often?</th>
<th>Reason</th>
<th>New?</th>
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