EmblemHealth®

Adult Comprehensive Health Assessment

Provider Name:			
Patient Name:		**Member ID:**	**Date of Service:**
Address:			**City:**
State:	**Zip:**	**Phone:**	
Gender:	**Race:**		**Preferred Language:**

Blood Pressure *(use exact values)*	Systolic	Diastolic

Significant Health Conditions					
Heart Disease	☐	Emphysema	☐	Crohn's Disease/Colitis	☐
Hypertension	☐	Stroke	☐	Arthritis	☐
Diabetes	☐	Cancer	☐	Liver Disease	☐
Kidney Disease	☐	Asthma	☐	Other:	

Colorectal Cancer Screening *(ages 45 – 75)*			
Test Type	**Date of Screening**	**Result**	**Test N/A**
			☐
Colorectal Cancer Screening Exclusion	**Date**		

Diabetic Health Screenings *(diabetic patients ages 18 and older)*			
Hemoglobin A1c Screening	**Date of Screening**	**Result Value**	**Test N/A**
HbA1c Blood Test *(once per year minimum)*			☐
Kidney Health Screening *(both urine and blood tests must be completed annually)*	**Date of Screening**	**Result Value**	**Test N/A**
Estimated Glomerular Filtration Rate Blood Test *(yearly)*			☐
Urine Albumin-Creatinine Ratio *(yearly)*			☐
Eye Exam *(must be completed by an eye care specialist)*	**Date of Screening**	**Retinopathy Result**	**Test N/A**
Diabetic Retinal Screening *(yearly)*			☐

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Woman's Health Screenings			
Breast Cancer Screening Test Type *(ages 50-74)*	**Date of Screening**	**Result**	**Test N/A**
Mammogram *(every 2 years)*			☐
Breast Cancer Screening Exclusion	**Date**		
Bilateral Mastectomy			
Osteoporosis Screening Test Type	**Date of Screening**	**Test N/A**	
Bone Mineral Density Test *(every 2 years)*			
Cervical Cancer Screening Test Type *(ages 21-64)*	**Date of Screening**	**Result**	**Test N/A**
			☐
Cervical Cancer Screening Exclusion	**Date**		
Total Hysterectomy			
Chlamydia Screening Test Type *(ages 18-24)*	**Date of Screening**	**Test N/A**	
		☐	

Pain Assessment	
Does the patient have pain?	
Please mark the level of pain **No Pain** **Moderate Pain** **Worst Pain** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	
Where in the body is the pain located? (Example: hip, knee, back, neck, etc.)	
In the past four weeks, how much has the pain interfered with normal activities both at home and outside of the home?	

Provider Name:	**NPI:**
Date Completed:	**TIN:**

Fax completed forms to **212-510-5936** or via secure email **HEDIS6@EmblemHealth.com.** If you have any questions, please mail to: **Quality_Providerengagement@emblemhealth.com.** Thank you for your partnership.

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