



2016 Quality Reporting for Medicare/Railroad Medicare Patients

Patient Name:	Date of Birth:	Date of Service:
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(Measure 47)

Do you have an Advanced Care Plan (Living Will)? YES NO (1123F/8P)

IF YES: Please name your Surrogate Decision Maker? _____ (1123F)

Please check this box if you are unable to, or choose not to name your Surrogate Decision Maker. (1124F)

(Measure 110)

Have you received an Influenza Immunization this year?

YES (G8482) NO (G8484)

(Measure 111)

Have you EVER (in your entire life) received a Pneumococcal Vaccination?

YES (4040F) NO (4040F/8P)

(Measure 128)

Please list your HEIGHT: _____ AND WEIGHT: _____

For Internal Use Only:

BMI Score: _____ ___Normal (G8420) ___Abnormal (G8419) ___Not Calculated (G8421)

(Measure 130)

Have you provided our office with a list of current medications? YES (G8427) NO (G8428)

(Measure 226)

Do you use Tobacco products?

(4004F) YES (PLEASE NOTIFY THE PROVIDER IF YOU WOULD LIKE INFORMATION OR COUNSELING ON STOPPING THE USE OF TOBACCO PRODUCTS)

(1036F) NO