MTM/CMR adult/child assessment

WellSense HEALTH PLAN

Patient Name: ____

Patient DOB: ____

Patient WellSense ID#:____

Provider Name: ____

Provider Practice Name: ____

Provider NPI#:____

1. Who is being interviewed?
   - ☐ Patient
   - ☐ Parent
   - ☐ Spouse/significant other
   - ☐ Legal guardian
   - ☐ Caregiver
   - ☐ Other: ____

2. List any medication allergies.

3. List ALL of the patient's medications, such as prescription, over-the-counter (OTC) and/or herbs/supplements.

4. Did you review with the patient all their current prescription medications?
   - ☐ No.
   - ☐ Yes.

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5. Did you review with the patient all their current OTC medications or herbs/supplements?
   - ☐ No.
   - ☐ Yes

6. Have you identified any medication therapy issues, such as drug interactions, duplicate therapies, etc.?
   - ☐ No.
   - ☐ Yes. Please explain and describe the interventions made for these medication therapy issues:

7. Is the patient experiencing any side effects from their medications?
   - ☐ No.
   - ☐ Yes. Please explain and describe the interventions made for managing patient side effects:

8. Has the patient ever had any problems in taking their medications exactly as prescribed?
   - ☐ No.
   - ☐ Yes. Please explain and describe solutions provided to the patient to overcome the problems in taking their medications as prescribed:

9. Over the last two weeks, which of the following would best describe how frequently the patient missed taking any of their medications as prescribed?
   - ☐ None/never.
   - ☐ Rarely – once or twice over the last two weeks.
   - ☐ Occasionally/sometimes – miss taking every now and then, but not on a regular basis.
   - ☐ Frequently/often – miss on a regular basis, ex: 3-4 times/week or more.
   - ☐ Most/all the time – miss taking more than half the time.

10. Is the member having any issues in getting their prescriptions filled?
    - ☐ No.
    - ☐ Yes. Please explain and describe the interventions made to help the patient get their prescriptions filled:

11. Has the patient had any of the following vaccinations?
    - ☐ COVID-19
    - ☐ Hepatitis A
    - ☐ Hepatitis B
    - ☐ Human Papillomavirus (HPV)
    - ☐ Influenza (within the last year)
    - ☐ Measles, mumps, rubella (MMR)
    - ☐ Meningococcal
    - ☐ Pneumococcal (within the last 5 years)
    - ☐ Tetanus, diphtheria, pertussis (TD/TDaP) (within the last 10 years)
    - ☐ Varicella
    - ☐ Zoster
    - ☐ Other:

      ____

12. Has the patient received the appropriate vaccinations based on their age, birth sex, and chronic condition(s)?
    - ☐ Yes.
    - ☐ No. Please list the vaccinations the member is eligible for and has not received:

Describe the plan for the member to receive all eligible vaccinations:

13. Have you identified any other barriers to care related to the patient's medication regimen that the patient may be experiencing?
    - ☐ No
    - ☐ Yes, please explain and describe the interventions made to help the patient overcome any barriers to care: