Magellan COMPLETE CARE.

Instructions: Please complete the following assessment for your MCC of AZ (HMO SNP) member. Please have the PCP sign the assessment, or a similar electronic health summary, and fax it to MCC of AZ (HMO SNP) at 1-888-656-2391.

Magellan Complete Care of Arizona (HMO SNP) – PCP Clinical Assessment		
Member Last Name	**Member First Name**	**DOB**
Member #	**Allergies**	**Immunizations Date** Flu Vx ☐____/__/___ Pneumo ☐___/____/___ Zoster ☐_____/__/___ Tetanus ☐ __/__/___
Health Care Proxy? Yes ☐ No ☐ Name and Contact Information	**Advance Directive?** Yes ☐ No ☐ Date:____/___/___	
Guardian? Yes ☐ No ☐ Name and Contact Information	Height: ____ feet_____ inches Weight: _____ BMI: _____ Date Taken: ____/_____/_____	**Pertinent Labs**

List Medical Diagnoses

Diabetes: Yes ☐ No ☐
If "yes," Last HbA1c Result:_____Date:_____/____/____

Hypertension: Yes ☐ No ☐
If "yes," Date Diagnosed:_____/____/____Most Recent BP:_____/_____Date:_____/____/____

Cancer Screenings:
Most recent Mammogram (if applicable): ____/____/____ Result: _____
Colorectal Cancer Screening:
Colonoscopy: Date:____/____/_____Result: _____
Flex Sig: Date:____/____/_____Result: _____
FOBT: Date:____/____/_____Result: _____

Other Medical or Behavioral Health Diagnoses

Medications: If more than five medications, please attach a list to this form.
Please have PCP sign attached list.

Medication Name	**Dose**	**Start Date (if known)**	**End Date (if known)**

Functional Status: ☐ Self Care ☐ Minimal Support ☐ Moderate Support ☐ Maximal Assist

Last ADL Screening Date: __/___/_____ Last IADL Screening: ____/__/___
Last Pain Screening: _____/___/____

What was last hospitalization date? (if known)
What is the member's risk for hospitalization in the next 90 days (1 is low risk – 5 is high risk) 1☐ 2☐ 3☐ 4☐ 5☐
What are some things you believe the member may need help with? Medication Adherence ☐ Nutrition Counseling ☐ Keeping Specialty Appointments ☐ Biometric Monitoring ☐ Other: ☐ Please contact MCC of AZ (HMO SNP) Member Services at 1-800-424-4509 with further concerns.
PCP Signature:_____ Date Signed:_____/_____/_____