

Name: _____

Date of Birth: _____

Account #: _____

Quality Measure Reporting

The Centers for Medicare & Medicaid Services (CMS) has mandated a quality program. As part of the program we have been assigned the following measures. We ask that you complete each question to help us maintain our compliance.

BMI *Please fill in the blanks*

Height _____ ft. _____ in.

Weight _____ lbs.

Influenza *Please select one of the following. * If you plan on receiving the flu vaccine, but have not yet done so please leave this section blank.**

_____ I received a flu vaccine for the 2019-2020 flu season

_____ I declined receiving the flu vaccine for the 2019-2020 flu season

_____ I declined the flu vaccine due to an allergy

Pneumonia (65 and over) *Please select one of the following*

_____ I have received a pneumonia vaccine

_____ I have never received a pneumonia vaccine

Falls Risk (65 and over) *Please circle Yes or No*

I have had a fall in the last year? Yes / No