QuadMed

TAKE**CONTROL**

CONDITION MANAGEMENT PROGRAM

PROVIDER ASSESSMENT FORM

(MD, DO, NP or PA)

ACTIVE MEMBER: Take this form to your condition managing provider or specialist when you visit for applicable program requirements. Once completed by your condition managing provider, it is your responsibility to return this form to the TakeControl Team. The information contained on the form will be used to verify that you have met the annual program requirements for active members. For additional copies, contact a TakeControl program coordinator at (228) 205-7667.

DON'T FORGET TO SEND A COPY OF THE COMPLETED FORM AFTER EACH APPOINTMENT.

PATIENT NAME (PLEASE PRINT) _____ DATE OF BIRTH ___/___/___

PROVIDER: Your patient has enrolled in TakeControl, the condition management program for asthma, diabetes and/or hypertension. Please fill out this form completely and either return it to the patient, email it to TakeControl@quadmedical.com or fax it to (228) 205-7715.

Note: If you are a QuadMed provider, you do not need to complete this form.

PROGRAM CRITERIA (Condition Managing Provider):	**VISIT DATE:** ___/___/___	
TOBACCO USE	**Patient is:** ☐ Tobacco-free ☐ Using Tobacco Quitting by: _____	
HEIGHT/WEIGHT/BMI	Weight _____ Height _____ BMI _____	Date
BLOOD PRESSURE	Systolic _____ / Diastolic _____	Date
CHOLESTEROL	Total Chol _____ HDL _____ LDL _____ TG _____	Date
ASTHMA ASSESSMENT (Asthma Only)	☐ Intermittent or EIB ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent Peak Flow _____ ACT _____ TRACK _____ Asthma Action Plan: ☐ Yes ☐ No	Date
HbA1C (Diabetes only)	HbA1C _____	Date
KIDNEY FUNCTION (Diabetes only)	Serum Creat _____ **OR** Microalbumin Urine _____ Creat Random Urine _____ Microalbumin Creat Ratio _____	Date
FOOT EXAM (Diabetes Only)	☐ Normal **OR** ☐ Ulcer ☐ Skin breakdown ☐ Absent pedal pulse(s) ☐ Neuropathy ☐ History of amputation ☐ Callus ☐ Deformity ☐ Abnormal toe nail(s) ☐ Other _____	Date
EYE EXAM (Diabetes only)	☐ Normal ☐ Diabetic Retinopathy ☐ Other _____	Date
SPECIALIST FOLLOW-UP	☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ Other _____	

NOTES/MEDICATION CHANGES:

PROVIDER SIGNATURE / DATE _____ **PLEASE PRINT (OR PROVIDE STAMP) / DATE** _____

QuadMed TakeControl Program | (228) 205-7667 (tel) | (228) 205-7715 (fax) | TakeControl@quadmedical.com (email)
Mail to: HII Family Health Center, Attn: TakeControl, 2105 Old Spanish Trail, Gautier, MS 39553

For internal use only:
Clinical Date: # _____