QuadMed

TAKECONTROL

CONDITION MANAGEMENT PROGRAM

PROVIDER ASSESSMENT FORM

(MD, DO, NP or PA)

ACTIVE MEMBER: Take this form to your provider or specialist when you visit for applicable program requirements. Once completed by your 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, visit the Quad TakeControl website or contact the TakeControl Team.

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

PATIENT'S FIRST NAME (PLEASE PRINT) _____ LAST NAME _____ DATE OF BIRTH (mm/dd/yyyy) _____

PROVIDER: Your patient has enrolled in TakeControl, the condition management program for asthma, COPD, diabetes and/or hypertension. Please fill out this form completely, sign it, and either return it to the patient or to the TakeControl Team using one of the options listed on the bottom of this form.

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

PROGRAM CRITERIA (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
RESPIRATORY ASSESSMENT (Asthma & COPD only)	Peak Flow _____ ACT _____ TRACK _____ Pulse Ox _____ CAT _____ 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
FOLLOW-UP RECOMMENDATION	☐ 3 Months ☐ 6 Months ☐ 12 Months ☐ Other _____	

NOTES/MEDICATION CHANGES:

PROVIDER SIGNATURE _____ DATE _____ PRINT PROVIDER NAME (OR PROVIDE STAMP) _____

RETURN COMPLETED FORM TO THE QUADMED TAKECONTROL PROGRAM TEAM USING ONE OF THE OPTIONS BELOW:

EMAIL	FAX	MAIL
TakeControl@quadmedical.com	414.566.8110	QuadMed Sussex, Attn: T akeControl, W227 N6103 Sussex Rd., Sussex, WI, 53089

  In select states, patient care is provided by a physician-owned medical practice contracted with QuadMed.

For internal use only:

Clinical Date: # _____