Arizona Priority Care

STAR ASSESSMENT FORM

Document STAR data for your patient and fax to 480-403-8219

Patient Name:_____ Date of Birth:_____ Date of Service:_____

Weight:_____ Height:_____ BMI:_____ Blood Pressure:_____

Diabetic Screenings: (Age 18-74; Annually)

Hemoglobin A1c Date:_____ Result:_____

Micro-Albumin/ Urine Protein Test Date:_____ Result: □ Positive □ Negative

Retinal Screen Date:_____ Result: □ Positive □ Negative

Med Screenings: (Age 18+)

DMARD:_____
Date:_____
Pharmacy:_____

ACEI/ARB filled □ Yes □ No
Date:_____

Preventive Screens:

Colorectal Cancer Screen (Age 50-75) Date:_____ Result:_____ Where:_____

□ Colonoscopy (every 10 years) □ Flexible Sigmoidoscopy (every 5 years) □ CT Colonography (every 5 years)
□ FIT-DNA (every 3 years) □ gFOBT/FIT-FOBT (annually)

Mammogram (Age 50-74; every 2 years) Date:_____ Result:_____ Where:_____

Bone Density Scan (Age 67-85; every 2 years) Date:_____ Result:_____ Where:_____

Influenza Vaccine (Age 18+; annually) □ Yes □ No

Pneumococcal Vaccine (Age 18): □ Yes □ No

Care of Older Adults: (Age 66+; Annually)

Pain Screen: Please rate pain using 0-10 pain scale (zero being no pain): _____

Functional Status: Check the box that most closely represents your patient.

Feeding	□ Independent	□ Needs some help	□ Dependent
Bathing	□ Independent	□ Needs some help	□ Dependent
Dressing	□ Independent	□ Needs some help	□ Dependent
Toilet Use	□ Independent	□ Needs some help	□ Dependent
Transfers (bed to chair and back)	□ Independent	□ Needs some help	□ Dependent
Mobility (on a level surface)	□ Independent	□ Needs some help	□ Dependent

Medication List: □ Medications Reviewed today: (***Attach active medication list)***

Advance Directive Discussed: □Yes □ No

PLEASE INCLUDE IN PATIENT'S PERMANENT RECORD

Provider Name:_____ Provider Signature:_____ MD, PA, NP Date Signed:_____