

Patient Summary Form

PSF-750 (Rev. 2/18/2009)

Instructions

Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

Female
 Male

Patient name: Last [] First [] MI [] Patient date of birth: [] [] []

Patient address: [] [] [] City [] State [] Zip code [] []

Patient insurance ID# [] Health plan [] Group number []

Referring physician (if applicable) [] Date referral issued (if applicable) [] Referral number (if applicable) []

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form) [] [] []

2. Federal tax ID(TIN) of entity in box #1 [] [] []

3. Name and credentials of the individual performing the service(s) [] [] []

4. Alternate name (if any) of entity in box #1 [] 5. NPI of entity in box #1 [] 6. Phone number [] [] []

7. Address of the billing provider or facility indicated in box #1 [] [] [] 8. City [] 9. State [] 10. Zip code [] []

Provider Completes This Section:

Date you want **THIS** submission to begin:

[] [] []

Patient Type

- 1 New to your office
- 2 Est'd, new injury
- 3 Est'd, new episode
- 4 Est'd, continuing care

Cause of Current Episode

- 1 Traumatic
- 2 Unspecified
- 3 Repetitive
- 4 Post-surgical
- 5 Work related
- 6 Motor vehicle

Date of Surgery

[] [] []

Type of Surgery

- 1 ACL Reconstruction
- 2 Rotator Cuff/Labral Repair
- 3 Tendon Repair
- 4 Spinal Fusion
- 5 Joint Replacement
- 6 Other [] []

Diagnosis (ICD code)

Please ensure all digits are entered accurately

1° [] [] [] [] [] []

2° [] [] [] [] [] []

3° [] [] [] [] [] []

4° [] [] [] [] [] []

Nature of Condition

- 1 Initial onset (within last 3 months)
- 2 Recurrent (multiple episodes of < 3 months)
- 3 Chronic (continuous duration > 3 months)

DC ONLY

Anticipated CMT Level

98940 98942
 98941 98943

Current Functional Measure Score

Neck Index [] [] DASH [] [] [] []
 Back Index [] [] LEFS [] [] [] [] (other) [] []

Patient Completes This Section:

Symptoms began on:

[] [] []

(Please fill in selections completely)

1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain
 Past week: no pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) worst pain

4. How often do you experience your symptoms?

- 1 Constantly (78%-100% of the time)
- 2 Frequently (51%-75% of the time)
- 3 Occasionally (26% - 50% of the time)
- 4 Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

- 1 Not at all
- 2 A little bit
- 3 Moderately
- 4 Quite a bit
- 5 Extremely

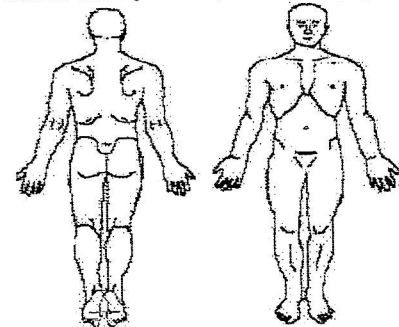
6. How is your condition changing, since care began at *this* facility?

- 0 N/A — This is the initial visit
- 1 Much worse
- 2 Worse
- 3 A little worse
- 4 No change
- 5 A little better
- 6 Better
- 7 Much better

7. In general, would you say your overall health right now is...

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

Indicate where you have pain or other symptoms:



Patient Signature: X

Date: _____