

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="radio"/> Female	<input type="text"/>
Patient name Last	First	MI	<input type="radio"/> Male	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	
<input type="text"/>		<input type="text"/>	
3. Name and credentials of the individual performing the service(s)			
<input type="text"/>			
4. Alternate name (if any) of entity in box #1		5. NPI of entity in box #1	
<input type="text"/>		<input type="text"/>	
7. Address of the billing provider or facility indicated in box #1		8. City	9. State
<input type="text"/>		<input type="text"/>	<input type="text"/>
		10. Zip code	<input type="text"/>

Provider Completes This Section:

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

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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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

- | | |
|-------------------------------------|---------------------------------------|
| <input type="radio"/> 1 Traumatic | <input type="radio"/> 4 Post-surgical |
| <input type="radio"/> 2 Unspecified | <input type="radio"/> 5 Work related |
| <input type="radio"/> 3 Repetitive | <input type="radio"/> 6 Motor vehicle |

Date of Surgery

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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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°	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2°	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3°	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4°	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

- | | |
|-----------------------------|-----------------------------|
| <input type="radio"/> 98940 | <input type="radio"/> 98942 |
| <input type="radio"/> 98941 | <input type="radio"/> 98943 |

Current Functional Measure Score

Neck Index	<input type="text"/>	DASH	<input type="text"/>	<input type="text"/>	<input type="text"/>
Back Index	<input type="text"/>	LEFS	<input type="text"/>	<input type="text"/>	(other) <input type="text"/>

Patient Completes This Section:

Symptoms began on:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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(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	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10	worst pain
Past week: no pain	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5	<input type="radio"/> 6	<input type="radio"/> 7	<input type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 10	worst pain

4. How often do you experience your symptoms?

- 1 Constantly (76%-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

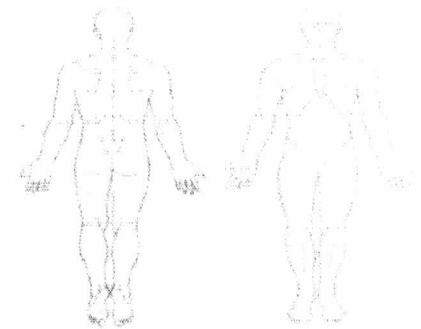
6. How is your condition changing, since care began at **this** facility?

- 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: _____