

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

Patient name Last		First	MI	<input type="radio"/> Female	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) 1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other						
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:

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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

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

Date of Surgery

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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°					
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		(other)	
Back Index		LEFS			

Patient Completes This Section:

Symptoms began on:

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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 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 (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

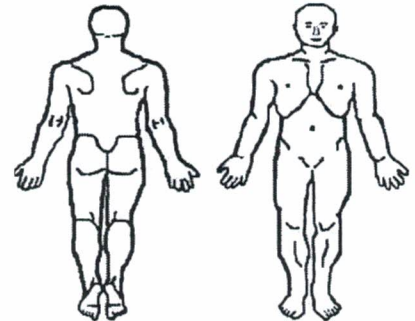
6. How is your condition changing, since care began at this facility?

- 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: _____



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The STarT Back Musculoskeletal Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

	Disagree 0	Agree 1
1 My pain has spread at some time in the past 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
2 In addition to my main pain, I have had pain elsewhere in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
3 In the last 2 weeks, I have only walked short distances because of my pain	<input type="checkbox"/>	<input type="checkbox"/>
4 In the last 2 weeks, I have dressed more slowly than usual because of my pain	<input type="checkbox"/>	<input type="checkbox"/>
5 It's really not safe for a person with a condition like mine to be physically active	<input type="checkbox"/>	<input type="checkbox"/>
6 Worrying thoughts have been going through my mind a lot of the time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
7 I feel that my pain is terrible and that it's never going to get any better	<input type="checkbox"/>	<input type="checkbox"/>
8 In general in the last 2 weeks, I have not enjoyed all the things I used to enjoy	<input type="checkbox"/>	<input type="checkbox"/>

9. Overall, how **bothersome** has your pain been in the last 2 weeks?

Not at all

0

Slightly

0

Moderately

0

Very much

1

Extremely

1

Originally developed by:

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