

Patient Summary Form

PSF-750 (Rev:12/11/2013)

Instructions

Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.

Please review the Plan Summary for more information.

Patient Information

<input type="text"/>	<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
<input type="text"/>					<input type="text"/>
Patient address			City	State	Zip code
<input type="text"/>		<input type="text"/>		<input type="text"/>	
Patient insurance ID#	Health plan	Group number			
<input type="text"/>		<input type="text"/>		<input type="text"/>	
Referring physician (if applicable)		Date referral issued (if applicable)		Referral number (if applicable)	
<input type="text"/>		<input type="text"/>		<input type="text"/>	

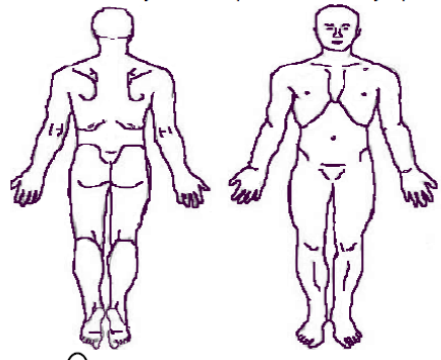
Provider Information

<input type="text"/>					<input type="text"/>				
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)					4. Alternate name (if any) of entity in box #1				
<input type="text"/>					<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				
<input type="text"/>					<input type="text"/>				
<input type="text"/>					9. State				
<input type="text"/>					10. Zip code				
<input type="text"/>					<input type="text"/>				

Provider Completes This Section:

<p>Date you want THIS submission to begin:</p> <input type="text"/>	<p>Cause of Current Episode</p> <p> <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 </p>	<p>Date of Surgery</p> <input type="text"/>	<p>Diagnosis (ICD code) <i>Please ensure all digits are entered accurately</i></p> <p>1° <input type="text"/></p> <p>2° <input type="text"/></p> <p>3° <input type="text"/></p> <p>4° <input type="text"/></p>
<p>Patient Type</p> <p> <input type="radio"/> 1 New to your office <input type="radio"/> 2 Est'd, new injury <input type="radio"/> 3 Est'd, new episode <input type="radio"/> 4 Est'd, continuing care </p>	<p>Type of Surgery</p> <p> <input type="radio"/> 1 ACL Reconstruction <input type="radio"/> 2 Rotator Cuff/Labral Repair <input type="radio"/> 3 Tendon Repair <input type="radio"/> 4 Spinal Fusion <input type="radio"/> 5 Joint Replacement <input type="radio"/> 6 Other _____ </p>	<p>Current Functional Measure Score</p> <p>Neck Index <input type="text"/> DASH <input type="text"/> <input type="text"/> <input type="text"/> (other)</p> <p>Back Index <input type="text"/> LEFS <input type="text"/></p>	
<p>Nature of Condition</p> <p> <input type="radio"/> 1 Initial onset (within last 3 months) <input type="radio"/> 2 Recurrent (multiple episodes of < 3 months) <input type="radio"/> 3 Chronic (continuous duration > 3 months) </p>	<p>DC ONLY</p> <p>Anticipated CMT Level</p> <p> <input type="radio"/> 98940 <input type="radio"/> 98942 <input type="radio"/> 98941 <input type="radio"/> 98943 </p>		

Patient Completes This Section:

<p>Symptoms began on: <input type="text"/></p> <p>(Please fill in selections completely)</p> <p>1. Briefly describe your symptoms:</p> <hr/> <p>2. How did your symptoms start?</p> <hr/> <p>3. Average pain intensity:</p> <p>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</p> <p>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</p> <p>4. How often do you experience your symptoms?</p> <p> <input type="radio"/> 1 Constantly (76%-100% of the time) <input type="radio"/> 2 Frequently (51%-75% of the time) <input type="radio"/> 3 Occasionally (26% - 50% of the time) <input type="radio"/> 4 Intermittently (0%-25% of the time) </p> <p>5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)</p> <p> <input type="radio"/> 1 Not at all <input type="radio"/> 2 A little bit <input type="radio"/> 3 Moderately <input type="radio"/> 4 Quite a bit <input type="radio"/> 5 Extremely </p> <p>6. How is your condition changing, since care began at this facility?</p> <p> <input type="radio"/> 0 N/A — This is the initial visit <input type="radio"/> 1 Much worse <input type="radio"/> 2 Worse <input type="radio"/> 3 A little worse <input type="radio"/> 4 No change <input type="radio"/> 5 A little better <input type="radio"/> 6 Better <input type="radio"/> 7 Much better </p> <p>7. In general, would you say your overall health right now is...</p> <p> <input type="radio"/> 1 Excellent <input type="radio"/> 2 Very good <input type="radio"/> 3 Good <input type="radio"/> 4 Fair <input type="radio"/> 5 Poor </p>	<p>Indicate where you have pain or other symptoms:</p> 
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Patient Signature: X _____

Date: _____

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

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DISABILITIES OF THE ARM, SHOULDER AND HAND

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

DISABILITIES OF THE ARM, SHOULDER AND HAND

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
22. During the past week, <i>to what extent</i> has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups? <i>(circle number)</i>	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
23. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem? <i>(circle number)</i>	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*

	NONE	MILD	MODERATE	SEVERE	EXTREME
24. Arm, shoulder or hand pain.	1	2	3	4	5
25. Arm, shoulder or hand pain when you performed any specific activity.	1	2	3	4	5
26. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
27. Weakness in your arm, shoulder or hand.	1	2	3	4	5
28. Stiffness in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
29. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? <i>(circle number)</i>	1	2	3	4	5

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. <i>(circle number)</i>	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = _____ ([(sum of n responses / n) - 1] x 25, where n is the number of completed responses.)

A DASH score may not be calculated if there are greater than 3 missing items.