

# 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"/>
<b>Patient name</b> Last	First	MI	<input type="radio"/> Male	<b>Patient date of birth</b>
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Patient address</b>		<b>City</b>	<b>State</b>	<b>Zip code</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Patient insurance ID#</b>	<b>Health plan</b>	<b>Group number</b>		
<input type="text"/>	<input type="text"/>	<input type="text"/>		
<b>Referring physician (if applicable)</b>	<b>Date referral issued (if applicable)</b>	<b>Referral number (if applicable)</b>		
<input type="text"/>	<input type="text"/>	<input type="text"/>		

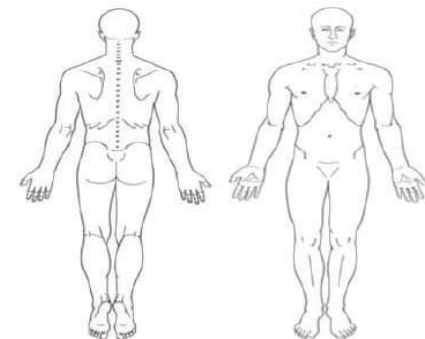
### Provider Information

<input type="text"/>		<input type="text"/>	
<b>1. Name of the billing provider or facility (as it will appear on the claim form)</b>		<b>2. Federal tax ID(TIN) of entity in box #1</b>	
<input type="text"/>		<input type="text"/>	
<b>3. Name and credentials of the individual performing the service(s)</b>		<b>4. Alternate name (if any) of entity in box #1</b>	
<input type="text"/>		<input type="text"/>	
<b>5. NPI of entity in box #1</b>		<b>6. Phone number</b>	
<input type="text"/>		<input type="text"/>	
<b>7. Address of the billing provider or facility indicated in box #1</b>		<b>8. City</b>	
<input type="text"/>		<input type="text"/>	
<b>9. State</b>		<b>10. Zip code</b>	
<input type="text"/>		<input type="text"/>	

### Provider Completes This Section:

<p><b>Date you want THIS submission to begin:</b></p> <input type="text"/>	<p><b>Cause of Current Episode</b></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><b>Date of Surgery</b></p> <input type="text"/>	<p><b>Diagnosis (ICD code)</b> Please ensure all digits are entered accurately</p> <p>1° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>2° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>3° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p>4° <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>
<p><b>Patient Type</b></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><b>Type of Surgery</b></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><b>DC ONLY</b></p> <p><b>Anticipated CMT Level</b></p> <p> <input type="radio"/> 98940    <input type="radio"/> 98942  <input type="radio"/> 98941    <input type="radio"/> 98943         </p>	
<p><b>Nature of Condition</b></p> <p> <input type="radio"/> (1) Initial onset (within last 3 months)  <input type="radio"/> (2) Recurrent (multiple episodes of &lt; 3 months)  <input type="radio"/> (3) Chronic (continuous duration &gt; 3 months)         </p>		<p><b>Current Functional Measure Score</b></p> <p>Neck Index <input type="text"/> DASH <input type="text"/> <input type="text"/> <input type="text"/></p> <p>Back Index <input type="text"/> LEFS <input type="text"/> <input type="text"/> (other)</p>	

### Patient Completes This Section:

<p><b>Symptoms began on:</b> <input type="text"/></p> <p>(Please fill in selections completely)</p> <p><b>1. Briefly describe your symptoms:</b></p> <hr/> <p><b>2. How did your symptoms start?</b></p> <hr/> <p><b>3. Average pain intensity:</b></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><b>4. How often do you experience your symptoms?</b></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><b>5. How much have your symptoms interfered with your usual daily activities?</b> (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><b>6. How is your condition changing, since care began at this facility?</b></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><b>7. In general, would you say your overall health right now is...</b></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> 
--	--

**Patient Signature:** X **Date:** \_\_\_\_\_

## THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	<b>Column Totals:</b>					

**Minimum Level of Detectable Change (90% Confidence): 9 points**

**SCORE: \_\_\_\_ / 80**

**Please submit the sum of responses.**

*Reprinted from Binkley, J., Stratford, P., Lott, S., Riddle, D., & The North American Orthopaedic Rehabilitation Research Network, The Lower Extremity Functional Scale: Scale development, measurement properties, and clinical application, Physical Therapy, 1999, 79, 4371-383, with permission of the American Physical Therapy Association.*

# Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

*This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.*

## Pain Intensity

- ⓪ The pain comes and goes and is very mild.
- ① The pain is mild and does not vary much.
- ② The pain comes and goes and is moderate.
- ③ The pain is moderate and does not vary much.
- ④ The pain comes and goes and is very severe.
- ⑤ The pain is very severe and does not vary much.

## Sleeping

- ⓪ I get no pain in bed.
- ① I get pain in bed but it does not prevent me from sleeping well.
- ② Because of pain my normal sleep is reduced by less than 25%.
- ③ Because of pain my normal sleep is reduced by less than 50%.
- ④ Because of pain my normal sleep is reduced by less than 75%.
- ⑤ Pain prevents me from sleeping at all.

## Sitting

- ⓪ I can sit in any chair as long as I like.
- ① I can only sit in my favorite chair as long as I like.
- ② Pain prevents me from sitting more than 1 hour.
- ③ Pain prevents me from sitting more than 1/2 hour.
- ④ Pain prevents me from sitting more than 10 minutes.
- ⑤ I avoid sitting because it increases pain immediately.

## Standing

- ⓪ I can stand as long as I want without pain.
- ① I have some pain while standing but it does not increase with time.
- ② I cannot stand for longer than 1 hour without increasing pain.
- ③ I cannot stand for longer than 1/2 hour without increasing pain.
- ④ I cannot stand for longer than 10 minutes without increasing pain.
- ⑤ I avoid standing because it increases pain immediately.

## Walking

- ⓪ I have no pain while walking.
- ① I have some pain while walking but it doesn't increase with distance.
- ② I cannot walk more than 1 mile without increasing pain.
- ③ I cannot walk more than 1/2 mile without increasing pain.
- ④ I cannot walk more than 1/4 mile without increasing pain.
- ⑤ I cannot walk at all without increasing pain.

## Personal Care

- ⓪ I do not have to change my way of washing or dressing in order to avoid pain.
- ① I do not normally change my way of washing or dressing even though it causes some pain.
- ② Washing and dressing increases the pain but I manage not to change my way of doing it.
- ③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ④ Because of the pain I am unable to do some washing and dressing without help.
- ⑤ Because of the pain I am unable to do any washing and dressing without help.

## Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor.
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑤ I can only lift very light weights.

## Traveling

- ⓪ I get no pain while traveling.
- ① I get some pain while traveling but none of my usual forms of travel make it worse.
- ② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ③ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ④ Pain restricts all forms of travel except that done while lying down.
- ⑤ Pain restricts all forms of travel.

## Social Life

- ⓪ My social life is normal and gives me no extra pain.
- ① My social life is normal but increases the degree of pain.
- ② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ③ Pain has restricted my social life and I do not go out very often.
- ④ Pain has restricted my social life to my home.
- ⑤ I have hardly any social life because of the pain.

## Changing degree of pain

- ⓪ My pain is rapidly getting better.
- ① My pain fluctuates but overall is definitely getting better.
- ② My pain seems to be getting better but improvement is slow.
- ③ My pain is neither getting better or worse.
- ④ My pain is gradually worsening.
- ⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back  
Index  
Score