

Patient Summary Form

PSF-750 (Rev: 7/1/2015)

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="radio"/> Female	<input type="text"/>
Patient name Last	First	MI	<input type="radio"/> Male	Patient date of birth
<input type="text"/>		<input type="text"/>	<input type="text"/>	<input type="text"/>
Patient address		City	State	Zip code
<input type="text"/>	<input type="text"/>	<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"/>																				
<table style="width:100%; border:none;"> <tr> <td style="border:1px solid black; padding:2px;">1</td> <td style="border:1px solid black; padding:2px;">MD/DO</td> <td style="border:1px solid black; padding:2px;">2</td> <td style="border:1px solid black; padding:2px;">DC</td> <td style="border:1px solid black; padding:2px;">3</td> <td style="border:1px solid black; padding:2px;">PT</td> <td style="border:1px solid black; padding:2px;">4</td> <td style="border:1px solid black; padding:2px;">OT</td> <td style="border:1px solid black; padding:2px;">5</td> <td style="border:1px solid black; padding:2px;">Both PT and OT</td> <td style="border:1px solid black; padding:2px;">6</td> <td style="border:1px solid black; padding:2px;">Home Care</td> <td style="border:1px solid black; padding:2px;">7</td> <td style="border:1px solid black; padding:2px;">ATC</td> <td style="border:1px solid black; padding:2px;">8</td> <td style="border:1px solid black; padding:2px;">MT</td> <td style="border:1px solid black; padding:2px;">9</td> <td style="border:1px solid black; padding:2px;">Other</td> <td style="border:1px solid black; padding:2px;">_____</td> </tr> </table>				1	MD/DO	2	DC	3	PT	4	OT	5	Both PT and OT	6	Home Care	7	ATC	8	MT	9	Other	_____
1	MD/DO	2	DC	3	PT	4	OT	5	Both PT and OT	6	Home Care	7	ATC	8	MT	9	Other	_____				
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"/>																				
6. Phone number		7. Address of the billing provider or facility indicated in box #1																				
<input type="text"/>		<input type="text"/>																				
8. City		9. State																				
<input type="text"/>		<input type="text"/>																				
10. Zip code		<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 codes) Please ensure all digits are entered accurately</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>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>	<p>Current Functional Measure Score</p> <p>Neck Index <input type="text"/> DASH <input type="text"/> (other FOM) <input type="text"/></p> <p>Back Index <input type="text"/> LEFS <input type="text"/></p>	

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 (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

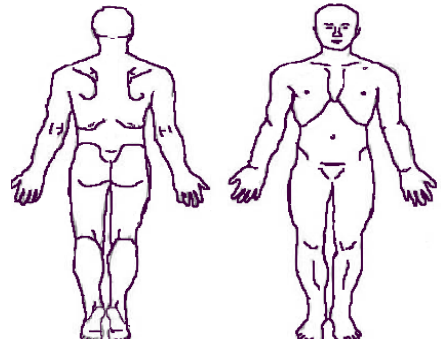
6. How is your condition changing, since care began at this facility?

(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:** _____

The Keele STarT Back Screening Tool

Patient name: _____ Date: _____

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

	No 0	Yes 1
1 Has your back pain spread down your leg(s) at some time in the last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
2 Have you had pain in the shoulder or neck at some time in the last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>
3 Have you only walked short distances because of your back pain?	<input type="checkbox"/>	<input type="checkbox"/>
4 In the last 2 weeks, have you dressed more slowly than usual because of back pain?	<input type="checkbox"/>	<input type="checkbox"/>
5 Do you think it's not really safe for a person with a condition like yours to be physically active?	<input type="checkbox"/>	<input type="checkbox"/>
6 Have worrying thoughts been going through your mind a lot of the time?	<input type="checkbox"/>	<input type="checkbox"/>
7 Do you feel that your back pain is terrible and it's never going to get any better?	<input type="checkbox"/>	<input type="checkbox"/>
8 In general have you stopped enjoying all the things you usually enjoy?	<input type="checkbox"/>	<input type="checkbox"/>

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

Not at all	Slightly	Moderately	Very much	Extremely
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0	0	0	1	1

Total score (all 9): _____ **Sub Score (Q5-9):** _____

The STarT Tool Scoring System

