

Prism Health Networks Treatment Form (TX)

GHI Fax: (716) 712 - 2817

Improperly Completed Forms Will Be Returned

Check all Contractual Visits Utilized
that apply: Referring PCP _____
 Referral Number _____

DC

Check if you are requesting another episode of care less than or equal to 30 calendar days from last patient visit: If so, complete Section 1 and attach at least 2 recent clinical evaluations. Evaluations must include case history, examination findings, clinical impression, treatment plan and diagnostic testing/imaging reports.

All other cases should only complete sections 1 and 2. Note: Section 2 cannot be used as a clinical evaluation.

Section 1 - Please print clearly.

Practitioner Name: _____ Practitioner ID Number: _____
Patient Name: Last: _____ Practitioner Phone Number: () _____
Patient Name: First: _____ Patient ID # _____
Group Number: _____ include alpha prefix
Group Name: _____ Other Health Insurance Coverage? No Yes
Patient's DOB: ___/___/___ Age: ___ Male Female Explain: _____

Area(s) of Patient Complaint(s): Neck Mid Back Low Back Date patient first seen this year: ___/___/___
Month Day Year Is this care for a No-Fault or Workers Comp. Injury/Incident? Yes No

For This Episode of Requested Care, indicate:
 New Injury Re-injury Chronic Insidious Traumatic
Primary Diagnosis: _____
Secondary Diagnosis: _____
Date Symptoms Began: ___/___/___ Examination Date: ___/___/___
Last Visit Seen: ___/___/___ Requested Begin Date: ___/___/___
 New Patient

Oswestry Disability Index Score (not percentage) _____
Neck Disability Index Score (not percentage) _____ Triple Visual Analog Scale Scores 1. _____ 2. _____ 3. _____

Section 2 - For chief complaint, please check the boxes that apply.

Range of Motion & Muscle Findings
Ranges of motion were Within Normal Ranges
 Mildly Moderately Severely reduced
 With Pain Without Pain
Muscle hypertonicity was
 WNL Mild Moderate Severe
Trigger Points Not Present
 With Radiation Without Radiation

Orthopedic Testing
 was WNL
 produced local mechanical pain
 reproduced local symptoms
 reproduced distal neurological symptoms

Neurological Findings
Motor deficit was Not Present
 neurologically related to the area of chief complaint
 biomechanical in nature
 Unilateral Bilateral
Reflex deficit that was neurologically related to the chief complaint was Not Present
 Unilateral deficit Bilateral deficit
Sensory deficit was Not Present
 could be objectified thru exam
 could NOT be objectified thru exam

Diagnostic Imaging Findings None Taken X-ray Date ___/___/___ CT Date ___/___/___ MRI Date ___/___/___
 WNL Pathology - Please attach report
 Disc Degeneration Mild Moderate Severe at _____
 Degenerative Spurring Mild Moderate Severe at _____
 IVF Encroachment Mild Moderate Severe at _____
 Lordosis/Kyphosis Mildly Moderately Severely Increased Decreased
 Listhesis Anteriorly Posteriorly of ___ on ___ that is approximately ___ millimeters
 Disc Herniation Contained Non-Contained Mild Moderate Severe at _____

Complicating Clinical Factors
 Obesity Diabetes/Smoker
 Occupational/Ergonomic Scoliosis
 Prior injury to same area Pregnancy
 Connective Tissue/Auto-immune

Treatment Adjustment Nutritional Support
 Modalities Exercise/Home Care

PHN Use Only

Additional information attached on _____ separate sheet(s).
PCP progress report sent? No Yes Date: ___/___/___

Practitioner Signature _____

Date _____