ICD-10 Compatible

DC Treatment Form (version 2.1)
www.palladianhealth.com/providers

Palladian

17761

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ● )

V:PalladianDCTtreatment(2.1)20150901

## Section A. Provider information

First Name | Last Name | Facility Name | Service Add. | NPI | State | Zip

## Section B. Patient information

First Name | Last Name | Health Plan | Member ID

Date of: Birth | Onset | Last Visit | Requested Start (M M - D D - Y Y Y Y)

## Section C. Primary region of complaint (select only 1 region) and primary diagnosis (ICD-10 number or text description)

- O Cervical
- O C/S+radiculopathy
- O Thoracic
- O Lumbosacral
- O L/S+radiculopathy

Shoulder O L O R | Elbow O L O R | Wrist O L O R | Hand O L O R

Hip O L O R | Knee O L O R | Ankle O L O R | Foot O L O R

O Headache | O Other

Authorization Request for: O Treatment only O X-ray only O Both

ICD-10

## Section D. Red flags (i.e. signs or symptoms that may indicate potentially serious pathology) and X-rays

Does this patient have any red flags (e.g. "yes" answers to DC Patient Intake Form questions 6-20)? O No O Yes

Does this patient have any contraindications to receiving DC care from you for this complaint? O No O Yes

X-rays: O None O Cervical O Thoracic O Lumbar O Other X-ray CPT Code

Rule out: O Fracture O Instability O Infection O Malignancy O Systemic inflammatory disease O Other

## Section E. Neurologic involvement associated with any spine condition

Which of the following symptoms or signs of neurologic involvement are present in the extremities?

Symptoms: O None O Radiating Pain O Paresthesia O Weakness

Signs: O None O Decreased sensation O Abnormal DTRs O Decreased strength O Pathologic reflex

What is the overall severity of the neurologic involvement associated with this spine condition?

O None O Very mild O Mild O Moderate O Severe O Very severe

## Section F. Evaluation

Based on information provided by the patient, your examination, and your treatment history with this patient (if any), what is your evaluation of this patient's primary spine condition? Please choose one box for each of these columns.

| Symptoms | Physical function | Overall health | Prognosis |
|---|---|---|---|
| O Very mild | O Very good | O Very good | O Very good |
| O Mild | O Good | O Good | O Good |
| O Moderate | O Moderate | O Moderate | O Moderate |
| O Severe | O Poor | O Poor | O Poor |
| O Very severe | O Very poor | O Very poor | O Very poor |

## Section G. Management plan (i.e. how you plan on managing this patient's complaint)

| | | | | | |
|---|---|---|---|---|---|
| Education about: | O Diagnosis | O Prognosis | O Remaining active | O Other | O None |
| Home/self-care: | O Heat/ice | O General exercises | O Specific exercises | O Other | O None |
| Supervised exercise: | O Strengthening | O Stretching | O Stabilization | O Other | O None |
| Modalities: | O Heat/ice | O TENS/EMS | O Ultrasound | O Other | O None |
| Manual therapy: | O Manipulation | O Mobilization | O Soft tissue | O Other | O None |

Number of DC visits used since last DC Treatment Form was submitted:

O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 10 O Other

Phone - - Fax - -

17761

Provider signature: X Date MM / DD / Y Y Y Y

Note: By completing and signing this form, the provider indicates that they:
1. provided all services, and 2. are a participating provider, and 3. provided all services in a credentialed practice.