



18650

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

Specialty: ○ PT ○ OT

NPI [Grid]

Section A. Provider information

Service Street Address [Grid]

First name, Last name, Facility name [Grids]

Date of Birth, Onset, Last visit, Requested start, Surgical/ Fracture [Grids]

Section B. Patient information

First name, Last name, Health plan, Member ID [Grids]

Section C. Primary region of complaint (select only 1 region)

Spine, Upper extremity, Lower extremity, Other, Rehabilitation [List of options]

ICD-10 [Grid]

Section D. Red flags (i.e. signs or symptoms that may indicate potentially serious pathology)

Does this patient have any red flags...? ○ No ○ Yes

Section E. 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 region of complaint? Please choose one box for each of these columns.

Symptoms, Physical function, Overall health, Prognosis [List of options]

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

Education about, Home/self-care, Supervised exercise, Modalities, Manual therapy [List of options]

Number of PT/OT visits used since last PT/OT Treatment Form was submitted: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ Other

Phone [Grid] - [Grid] - [Grid] Fax [Grid] - [Grid] - [Grid]

Provider signature: X [Signature line]

Date [Grid] / [Grid] / [Grid]

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V:PalladianPTOTreatment(2.1)20150901



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