ICD-10 Compatible

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

Palladian

18650

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

Specialty: ○ PT ○ OT

NPI

Section A. Provider information

First name

Last name

Facility name

Service Street Address

Section B. Patient information

First name

Last name

Health plan

Member ID

Date of Birth (M M - D D - Y Y Y Y)

Onset

Last visit

Requested start

Surgical/ Fracture

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

Spine
- ○ Cervical
- ○ C/S+radiculopathy
- ○ Thoracic
- ○ Lumbosacral
- ○ L/S+radiculopathy

Upper extremity
- Shoulder ○ L ○ R
- Elbow ○ L ○ R
- Wrist ○ L ○ R
- Hand ○ L ○ R

Lower extremity
- Hip ○ L ○ R
- Knee ○ L ○ R
- Ankle ○ L ○ R
- Foot ○ L ○ R

Other (also indicate region)
- ○ Post-surgical
- ○ Fracture
- ○ Other

Rehabilitation
- ○ Stroke
- ○ Spinal cord
- ○ Neurological
- ○ Balance/coordination

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

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

Does this patient have any contraindications to receiving PT/OT care from you for this complaint? ○ 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 <u>one</u> box for each of these columns.

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

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

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

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 - - Fax - -

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

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V:PalladianPTOTtreatment(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.