### Section A. Provider information
- Specialty: [ ] PT  [ ] OT
- NPI: 
- Service Street Address: 
- Date of Birth: MM DD YYYY
- Onset: MM DD YYYY
- Last visit: MM DD YYYY
- Requested start: MM DD YYYY
- Surgical/Fracture: MM DD YYYY

### Section B. Patient information
- First name: 
- Last name: 
- Health plan: 
- Member ID: 

### 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): [ ]
- Rehabilitation
  - Post-surgical: [ ]
  - Fracture: [ ]
  - Other: [ ]

### 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)? [ ] Yes [ ] No
- Does this patient have any contraindications to receiving PT/OT care from you for this complaint? [ ] Yes [ ] No

### 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
    - Very mild: [ ]
    - Mild: [ ]
    - Moderate: [ ]
    - Severe: [ ]
    - Very severe: [ ]
  - Physical function
    - Very good: [ ]
    - Good: [ ]
    - Moderate: [ ]
    - Poor: [ ]
    - Very poor: [ ]
  - Overall health
    - Very good: [ ]
    - Good: [ ]
    - Moderate: [ ]
    - Poor: [ ]
    - Very poor: [ ]
  - Prognosis
    - Very good: [ ]
    - Good: [ ]
    - Moderate: [ ]
    - 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 [ ]

Provider signature: [X]
Date: MM DD YYYY

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.