Clinical Information Summary Sheet

The purpose of the Clinical Information Summary Sheet is to document the significant clinical findings that contribute to the formulation of the member's diagnosis and treatment protocol. It is the standard tool you may use to communicate with the peer clinical quality evaluator when submitting treatment/services for verification of Medical Necessity. This tool is a summary, does not constitute a complete or adequate record, and should not be used as your primary history and examination form.

The Clinical Information Summary Sheet may be used for:

1. Documenting findings from a new patient examination
2. Documenting an established patient's clinical exam findings if they suffer a new injury/condition
3. Documenting an established patient's clinical exam findings if they suffer an exacerbation which requires a new treatment plan
4. Documenting established patient examination findings if continuing care is necessary or the member is not progressing as expected

The following are general guidelines for completing the Clinical Information Summary Sheet.

Section I: Treatment Outcome

What are the goals of the treatment plan and how are you measuring progress toward those goals? How has the patient responded to the treatments so far? It is especially important to note measurable changes in Pain Levels, Examination Findings and Functional Abilities.

Section II: Current Complaints

In this section list the:

- Chief Complaint/the specific location
- The date each complaint began. If the date is unknown, please estimate or use a descriptor such as "gradual", "insidious", or "unknown".
- The cause or mechanism of injury (how the complaint began)
- The initial pain level when you started this treatment plan and the current pain level. Pain should be rated on a zero to ten scale with zero being no pain and ten being the worst pain the patient can imagine.
- How long the pain relief lasts after the treatments.
- The pain frequency as a percentage of time the pain is present
- Your observations – gait changes, energy level, mood, shen, swelling, color changes, etc.
- Tenderness to palpation rated on a 0-4 scale.
- Range of motion if it is applicable. You can describe as an estimate of % limited or give the joint, plane of motion and degrees.

Include any pertinent past medical history or co-morbid conditions that may affect recovery from the current episode (such as obesity, prior injury, diabetes, previous surgery, etc.). Any other barriers to care such as transportation constraints, schedule conflicts, etc.

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Section III: Functional Assessments

List activities that are important to the patient and how they are being affected by the treatments. Examples might be working, driving, walking, household chores. Include specific measurable changes.

List any standardized functional outcome measures you have completed with the patient. Be sure to include the name of the outcome measure, body area or condition, date, and the score. If there is more than one over time, please document how the patient's score has changed.

Has there been a significant change in pain medication uses during acupuncture services?

Section IV: Co-Management

Document whether the patient is being seen with a medical physician and for what condition.

If the patient is less than three years old, include documentation of a referral on file in your records.

If the patient is 3-11 years old, document that their physician is aware they are seeking acupuncture.

If the patient is pregnant, please document medical physician care and the number of weeks of the pregnancy.

Section V: Vital Signs

Include vital signs such as height, weight, blood pressure, temperature if you have them. Please at least check a blood pressure at the initial visit and if needed thereafter.

Enter the tongue and pulse signs.

Section VI: Additional Comments

Please add relevant information that might not have been covered elsewhere on this form.

Signature

Be sure to sign and date the form.

Clinical Information Summary Sheet

Practitioner Name: _____

Patient Name: _____

SECTION I. Treatment Outcome

Treatment Goals: _____

How are you measuring progress toward goals? _____

Patient's response to most recent treatment: _____

_____

SECTION II. Current Main Complaint(s)

Date of Examination: _____

#1 Complaint/Location: _____ **Date of Onset**: _____ **Cause of Condition**:_____

Initial Pain Level: _____**Current Pain Level:** _____**How Long Pain Relief Lasts**: _____ **Pain frequency %** _____

Observation (gait, swelling, color, shen, etc.) _____

Tenderness to Palpation (0-4): _____ **Range of Motion (% limited):** _____

Other History of Complaint: _____

#2 Complaint/Location: _____ **Date of Onset**: _____**Cause of Condition**:_____

Initial Pain Level: _____**Current Pain Level:** _____**How Long Pain Relief Lasts**: _____ **Pain frequency %** _____

Observation (gait, swelling, color, shen, etc.) _____

Tenderness to Palpation (0-4): _____ **Range of Motion (% limited):** _____

Other History of Complaint: _____

Comments (e.g., Pertinent Health History or Barriers to Progress): _____

SECTION III: Functional Assessments

List the activities (sleep, work, recreation) you are monitoring for progress and any measurable results

Activity	Measurements (how much, how long, how far)	How has it changed?

List Functional Outcome Tool Name, Body Area or Condition, Date and Score.

Functional Tool Name	Body Area/Condition	Date	Score

Recent Changes in Pain Medication:_____

SECTION IV: Co-Management

Patient is Cared for by a Medical Physician: ☐ **No** ☐ **Yes: For What Condition:** _____ _____

If patient under 3 years old, do you have a written referral for acupuncture on file from their medical physician?Y☐ **N**☐

If patient is 3-11 years old, is their medical physician aware they are receiving acupuncture for this condition? Y☐**N**☐

Is this patient Pregnant? ☐ **No** ☐ **Yes; If yes, # weeks**_____ **Medical practitioner for pregnancy care?** ☐ **No** ☐ **Yes**

SECTION V: Vital Signs

Height_____**Weight** _____**BP**_____ / ____ , **Temp** _____, Tongue _____, Pulse R_____L_____

SECTION VI: Additional Comments _____

_____

Signature of Treating Practitioner _____ **Date** _____