American Specialty Health (ASH)
P. O. Box 509001, San Diego, CA 92150-9001
FAX: 877.248.2746

PROGRESS EVALUATION

Kaiser Permanente Acupuncture Referral Program

For questions, please call ASH at 888.226.8879

Patient Name _____ **Date** _____

Kaiser Permanente Medical Record Number _____

Referring Kaiser Permanente Physician _____ **Phone #** _____

FAX Number _____

Treating Acupuncturist _____ **Phone #** _____ **Fax #** _____

Diagnosis Name _____ **Referring ICD 10 Code** _____

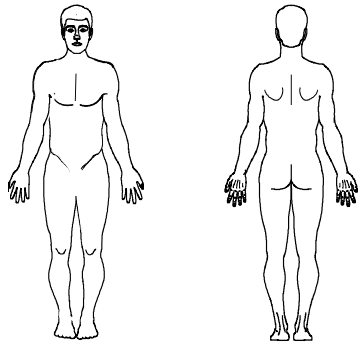
***Patient**: Please complete the following portion of this form.*

Current Conditions/Complaints	Rate your overall progress since starting care
1. _____	____ % (or circle one) no progress fair good excellent
2. _____	____ % (or circle one) no progress fair good excellent

I. Circle your pain level

0 1 2 3 4 5 6 7 8 9 10

No Pain — Unbearable



Has your pain improved? ☐ Yes ☐ No

Is the relief only temporary? ☐ Yes ☐ No

For how long? _____ hrs/days

II. In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities, or household chores)?

0 1 2 3 4 5 6 7 8 9 10

No Interference — Unable to carry on any activities

Patient Signature: _____ **Date:** _____

***Treating Acupuncturist**: Please Complete the Following Summary.*

Treating Acupuncturist Diagnosis Name: _____ **ICD9 Code:** _____

The current Acupuncture Treatment Plan Includes:

☐ Acupuncture treatment
☐ Nutritional supplements/herbs
☐ Cupping
☐ Moxibustion
☐ TuiNa/Acupressure/Massage therapy
☐ Rehab Exercise
☐ Home Care Advice
☐ Other _____

Based on Your Clinical Expertise, the Previous Acupuncture Treatments Were Considered:

☐ Successful ☐ Some improvement ☐ Unsuccessful ☐ Reached maximum therapeutic benefit ☐ Other_____

III. How would you rate the quality of your patient's daily function or functional abilities

0 1 2 3 4 5 6 7 8 9 10

High functional ability — Unable to carry on any functional abilities

What Would You Like to Recommend to the patient's Referring Physician? (Check all that apply)

☐ Continued acupuncture treatment ☐ Discharge the patient from acupuncture care ☐ Refer to other practitioner
☐ Return patient to referring physician for evaluation ☐ Call me to discuss any future care ☐ Other: _____

Comments: _____

Acupuncturist Signature: _____ **Date:** _____