Clinical Information Summary Sheet

The purpose of the Clinical Information Summary Sheet is to document the pertinent clinical findings that contribute to the formulation of the member's diagnosis and treatment plan. It is the standard tool you may use to communicate with the Peer Clinical Quality Evaluators (CQE) 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 evaluation form.

The Clinical Information Summary Sheet may be used for:

1. Documenting findings from an initial evaluation, re-evaluations and/or assessments
2. Documenting a patient's clinical findings if they suffer a new injury/condition
3. Documenting a patient's clinical findings if continuing care is necessary or the patient is not progressing as expected

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

Section I: Historical Information

In this section list each Chief Complaint, the date each complaint began (or if the date is unknown use a descriptor such as "gradual," "insidious," or "unknown"), the cause / mechanism of injury (how each complaint began), and the Stage and Nature of the condition.

Section II: Clinical Information

This section allows you to report what you found in your evaluation, reevaluation, or assessment. This form is available for practitioners to submit objective findings or any pertinent clinical information to support interventions/care needed. Examples of clinical findings may include but are not limited to: 1) any range-of-motion findings as degrees or percent (%) limited, 2) comment on any pain or other pertinent findings associated with the motion in the "Comments" section, 3) any pertinent subjective and objective findings,
4) clinical assessment or updated goals. Be sure to be specific regarding the findings. For example, do not merely state a test was positive. A finding reported as "positive" is not meaningful without a description of the side on which the finding was noted, and the location and character of the symptom produced.

Section III: Outcome Assessments

In this section, list an appropriate type of outcome assessment tool for the patient's condition. If this is your initial assessment, list the score obtained. If this is ongoing care, please provide both the initial score and the current score. We have specifically listed the most commonly used tools. List any other tools by name and score in the "Other" section.

Additional Comments

Please do not hesitate to provide any additional information you feel is important for us to know regarding the patient's condition that will aid us in making a medical necessity determination.

Clinical Information Summary Sheet

☐ New or ☐ Continuing Rehabilitative Care

Practitioner________________________________ Patient______________________________

Date of Findings Below:_______________

I. Date of Onset/Exacerbation__________ Initial Start care (mm/dd/yyyy) for this condition__________

Chief Complaint(s)______________________________ ______________________________

Cause of Current Episode: ☐ Traumatic ☐ Repetitive ☐ Unknown

☐ Post-Surgical (date/type)______________________________

Stage of Condition ☐ Acute ☐ Sub-acute ☐ Chronic

Nature of Condition ☐ Initial Occurrence ☐ Exacerbation ☐ Recurrent / Chronic

II. Vital Signs Height________ Weight_________ Blood Pressure______________________________

Area/Joint Movement	Active ROM R/L(Degrees)	Passive ROM R/L (Degrees)	Strength R/L (0-5)	Mobility (0-6, 3=NL)	End Feel	Pain (Level/Location)
	/	/	/			
	/	/	/			
	/	/	/			
	/	/	/			
	/	/	/			

Pertinent Evaluation Findings (Please include location and intensity of findings and note any significant progress)____

Patient's Goals, Functional Limitations & Planned Interventions______________________________

Medical /Social History &/or Co-Morbidities (that may affect recovery)______________________

III. OUTCOME ASSESSMENTS (List both Initial / Current date(s) and score(s) as applicable)

Initial	List Date Obtained (mm/dd/yyy)	Current	Initial	List Date Obtained (mm/dd/yyy)	Current
________	ROLAND-MORRIS	________	________	NECK INDEX (NDI)	________
________	OSWESTRY	________	________	OPTIMAL SCORE	________
________	FOTO	________	________	LEFS (LE) score	________
________	Other (name and score)	________	________	DASH (UE) score	________
________	________________	________	________	Other (name and score)	________

ADDITIONAL COMMENTS____

Signature of treating practitioner (Required)______________________________ **Date**__________________

Practitioners are encouraged to submit additional information as necessary to support the interventions / care submitted