

## **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 evaluation manager 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 or initial evaluation and re-evaluations
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: 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 pain level for each complaint on a zero to ten scale with ten being the worst, the mechanism of injury (how each complaint began), and any pertinent past medical history or co-morbid condition that may affect recovery from the current episode (such as obesity, prior injury, diabetes, previous surgery, etc.).

### **Section II: Examination Information**

This section allows you to report what you found in your examination. Please state the date of the examination. List any range-of-motion findings as degrees or percent (%) limited. You may also comment on any pain or other findings associated with the motion in the "Comments" section. List any pertinent orthopedic, neurologic, or vascular testing findings. Be sure to be specific regarding the finding. For example, do not merely state a test was positive. A finding reported as "positive straight leg raise" is not meaningful without a description of the side on which the finding was noted and the location and character of the pain produced. List any palpation findings that contribute to the clinical picture such as the location of subluxation, trigger points, muscle tightness, and tenderness to touch. You may also report postural findings here. In the "Functional Assessment" section list any results from functional assessment testing (e.g. Repetitive Squats, Horizontal Side Bridge Test for Muscular Endurance, Sorenson Test for Muscular Endurance and Single Leg Stand Balance Test - Eyes open and closed) as well as any noted limitations in the performance of activities of daily living (ADL).

### **Section III: Therapeutic Goals And Outcome Assessments**

In this section, list your goals of treatment (e.g. "pain relief"; "improvement in the ability to bend and lift"; "normal range of motion"; etc.). In addition, provide information regarding your plans for patient self-care such as exercises or home care measures. It is helpful to perform some type of outcome assessment tool. 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 neck and low back tools. List any other tools in the "Other" section. It is helpful to report the patient's perceived improvement in this section as well.

### **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

Practitioner Name \_\_\_\_\_

Patient Name \_\_\_\_\_

## I. Historical Information

**CHIEF COMPLAINT(s)** with date(s) of onset: (mm/dd/yy) \_\_\_\_\_

**0 – 10 Pain Level** \_\_\_\_\_

**Mech. of Injury/Exacerbation** \_\_\_\_\_

**Pertinent Past History / Co-Morbidities** \_\_\_\_\_

## II. Examination Information

**Date of Exam** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Vital Signs:** Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_ Temp \_\_\_\_\_

### **Range of Motion**

**Cervical spine:**  N/A  All WNL **Flexion** \_\_\_\_/60 or \_\_\_\_% limited **Extension** \_\_\_\_/50 or \_\_\_\_% limited

**Lateral Flexion:** Left \_\_\_\_/40 or \_\_\_\_% limited Right \_\_\_\_/40 or \_\_\_\_% limited

**Rotation:** Left \_\_\_\_/80 or \_\_\_\_% limited Right \_\_\_\_/80 or \_\_\_\_% limited

**Comments** \_\_\_\_\_

**Lumbo-sacral:**  N/A  All WNL **Flexion** \_\_\_\_/90 or \_\_\_\_% limited **Extension** \_\_\_\_/30 or \_\_\_\_% limited

**Lateral Flexion:** Left \_\_\_\_/20 or \_\_\_\_% limited Right \_\_\_\_/20 or \_\_\_\_% limited

**Rotation:** Left \_\_\_\_/30 or \_\_\_\_% limited Right \_\_\_\_/30 or \_\_\_\_% limited

**Comments:** \_\_\_\_\_

**Extremity / Other:** \_\_\_\_\_

**Ortho / Neuro / Vascular / VBI:**  NA  WNL (Please include location and intensity of any findings.) \_\_\_\_\_

**Chiropractic / Palpation / Postural Assessment** \_\_\_\_\_

**Functional Assessment / Improvement** \_\_\_\_\_

## III. Therapeutic Goals And Outcome Assessments

**Therapeutic Goals** \_\_\_\_\_

**Exercise/Home Care Instructions** \_\_\_\_\_

**Outcome Assessments:**  N/A **Date score obtained:** \_\_\_\_\_

Neck Disability score: Initial \_\_\_\_\_ Current \_\_\_\_\_  Roland-Morris score: Initial \_\_\_\_\_ Current \_\_\_\_\_

Oswestry score: Initial \_\_\_\_\_ Current \_\_\_\_\_  Perceived Improvement \_\_\_\_\_%

Other (name) score: Initial \_\_\_\_\_ Current \_\_\_\_\_

**ADDITIONAL COMMENTS** \_\_\_\_\_

**Signature of treating D.C. (Required)** \_\_\_\_\_ **Date** \_\_\_\_\_