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 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) _____

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**_____