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/symptom description and treatment protocol. It is the standard tool you may use communicate with the peer clinical 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 assessment or initial assessment and re-assessments
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: COMPLICATING CONDITIONS / FACTORS (From History)

In this section list 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.). You should also report any co-management in this section.

Section II: HEALTH STATUS

This section allows you to provide information about the Chief complaint(s) as well as the cause and stage of the current episode.

Section III: CURRENT ASSESSMENT FINDINGS TO MONITOR PROGRESS

This section allows you to report your assessment findings including the location, character, and severity of tenderness, trigger points, spasm, or joint pain. It also includes simple outcome assessment tools.

Additional Comments

Please so 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. COMPLICATING CONDITIONS / FACTORS (From History)

☐ **None** ☐ **Cancer** ☐ **Stroke**
☐ **Osteoporosis** ☐ **High Blood Pressure** ☐ **Diabetes** ☐ **Obesity**
☐ **Pregnant, # Weeks**_____ ☐ **Smokes, Packs per day** _____
☐ **Other**_____

Is Co-management Occurring? ☐ No ☐ Yes
By whom? ☐ MD/DO ☐ Chiropractor ☐ Physical Therapist ☐ Acupuncturist ☐ Other_____

II. HEALTH STATUS

Date of Onset/Exacerbation: (mm/dd/yyyy)____ / _____ / _____
☐ **Unknown** (Insidious / Gradual)
Chief Complaint(s): ☐ Headache ☐ Neck Pain ☐ Upper Back Pain ☐ Mid-Back Pain
☐ Low Back Pain ☐ Neck Pain with Pain into Extremity ☐ Low Back Pain with Pain into Extremity ☐ Shoulder Pain ☐ Elbow Pain ☐ Wrist/Hand Pain ☐ Hip Pain ☐ Knee Pain ☐ Ankle/Foot Pain
☐ Additional Symptoms/Complaints_____

Cause of Current Episode: ☐ Traumatic ☐ Repetitive ☐ Unknown
☐ Post-Surgical (date / type)_____
Stage of Condition: ☐ Acute (up to 6 weeks) ☐ Sub-acute (6 to12 weeks) ☐ Chronic (>12 weeks)
Nature of Condition: ☐ Initial Occurrence ☐ Exacerbation ☐ Recurrent / Chronic

III. CURRENT ASSESSMENT FINDINGS TO MONITOR PROGRESS.

Date of Assessment Findings: (mm/dd/yyyy)_____/ _____ / _____

Anatomical Location ↓	Tenderness 1 = Mild 4 = Severe	Trigger Points 1 = Active 2 = Latent	Spasm 1 = Mild 2 = Moderate 3 = Severe	Pain on Motion A= Absent S = Sharp D = Dull L = Localized R = Radiating	Comments (Provide additional information as desired for any of the information to the left)
	1 2 3 4	1 2	1 2 3	A S D L R	
	1 2 3 4	1 2	1 2 3	A S D L R	
	1 2 3 4	1 2	1 2 3	A S D L R	
	1 2 3 4	1 2	1 2 3	A S D L R	

Outcome Assessment Tools* – Minimally a Numeric Pain Rating Scale (NPRS) is REQUIRED -List both Initial / Current date(s) and Score(s):

	Initial	Current		Initial	Current
List Date Obtained (mm/dd/yyyy)	___ / ___ / _____	___ / ___ / _____	List Date Obtained (mm/dd/yyyy)	___ / ___ / _____	___ / ___ / _____
NPRS (0-10)	_____	_____	Other_____	_____	_____

Does the patient currently have any limitations to Activities of Daily Living? ☐ **No** ☐ **Yes, Describe:**___

_____

Is there any other clinical information you would like to share?_____

_____

You are encouraged to submit additional information as necessary to support the care submitted.

By affixing my signature, I declare that the information on this form is true and accurate. In my professional judgment, my interventions are within my scope of practice, are clinically appropriate and are not contraindicated for this patient.

Signature of Massage Therapist (Required) _____**Date**____ / ____ / _____