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 evaluator 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:

Document the total time spent on E/M services provided on the day of the visit or anticipated per visit. This time would not include non-E/M services such as time spent providing therapies or services of health care staff other than the Naturopath. Alternatively, document the level of medical decision-making to support the E/M service code chosen.

Section II:

In this section describe the patient's current health condition(s), complaints and all pertinent past medical history or co-morbid condition (s) that may affect recovery from the current episode (such as obesity, prior injury, diabetes, previous surgery, etc.).

Section III:

This section allows you to report what you found in your examination. If treatment is for a neuro-musculo-skeletal (NMS) condition, list any pertinent, ROM, orthopedic, neurologic, or vascular testing findings. Be sure to be specific regarding the findings. For example, do not merely state a test was positive. A finding is not meaningful without a description of the side on which the finding was noted and the location and character of the symptom re-produced. List any palpation findings that contribute to the clinical picture such as the location of trigger points, muscle tightness, and tenderness to touch. You may also report postural findings here. You should use this section to include any other tests or findings you have noted in your evaluation of non-NMS conditions. You may include pertinent lab or other diagnostic test results. Please include vital signs for all patients.

Section IV:

In this section, list your specific objectives/goals of treatment. In addition, provide information regarding your plans for patient self-care management such as dietary, exercise and/or lifestyle changes.

Additional Comments

Please do not hesitate to provide any additional information you feel is important for us to know regarding the patient's condition(s) that will aid us in making a medical necessity determination. You may also submit your chart notes, exam forms or other pertinent clinical records.

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Practitioner Name:_____

Patient Name:_____

I. Is E/M code choice based on Time or Level of Medical Decision-Making (MDM)?

☐ **TIME (#minutes _____). Total E/M time spent by physician/other qualified health care provider on date of the encounter**

OR ☐ **Medical Decision-Making _____** ☐ **straightforward** ☐ **low** ☐ **moderate** ☐ **high**_____

II. CURRENT/PAST HEALTH HISTORY_____

III. OBJECTIVE FINDINGS_____

VITAL SIGNS: Ht_____ **Wt**_____ **B/P**_____ **Pulse**_____ **Temperature**_____

LAB and/or other Diagnostic Testing Results_____

IV. TREATMENT OBJECTIVES/GOALS_____

PATIENT EDUCATION/RISK MANAGEMENT_____

ADDITIONAL COMMENTS OR ATTACH YOUR DAILY NOTES OR OTHER CLINICAL RECORDS

Signature of Treating Practitioner_____ **Date**_____

(Required)