

Patient Summary Form

PSF-750 (Rev:2/18/2009)

Instructions

Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

<input type="text"/>			<input type="radio"/> Female	<input type="text"/>					
<input type="text"/>			<input type="radio"/> Male	<input type="text"/>					
Patient name Last		First		MI		Patient date of birth			
Patient address				City		State		Zip code	
Patient insurance ID#			United Healthcare			Group number			
Referring physician (if applicable)			Date referral issued (if applicable)			Referral number (if applicable)			

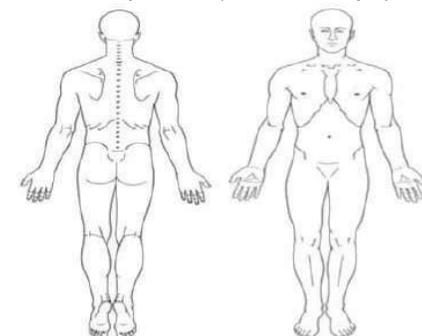
Provider Information

TRINITY REHAB					46-1529622					
1. Name of the billing provider or facility (as it will appear on the claim form)					2. Federal tax ID(TIN) of entity in box #1					
<input type="text"/>					<input type="text"/>					
3. Name and credentials of the individual performing the service(s)					6. Phone number					
<input type="text"/>					<input type="text"/>					
4. Alternate name (if any) of entity in box #1					5. NPI of entity in box #1					
<input type="text"/>					<input type="text"/>					
7. Address of the billing provider or facility indicated in box #1					8. City		9. State		10. Zip code	
113 S. RAILROAD AVE.					DUNN		NC		28334	

Provider Completes This Section:

Date you want THIS submission to begin: <input type="text"/>	Cause of Current Episode <input type="radio"/> (1) Traumatic <input type="radio"/> (2) Unspecified <input type="radio"/> (3) Repetitive <input type="radio"/> (4) Post-surgical <input type="radio"/> (5) Work related <input type="radio"/> (6) Motor vehicle	Date of Surgery <input type="text"/>	Diagnosis (ICD code) Please ensure all digits are entered accurately 1° <input type="text"/> 2° <input type="text"/> 3° <input type="text"/> 4° <input type="text"/>
Patient Type <input type="radio"/> (1) New to your office <input type="radio"/> (2) Est'd, new injury <input type="radio"/> (3) Est'd, new episode <input type="radio"/> (4) Est'd, continuing care	Type of Surgery <input type="radio"/> (1) ACL Reconstruction <input type="radio"/> (2) Rotator Cuff/Labral Repair <input type="radio"/> (3) Tendon Repair <input type="radio"/> (4) Spinal Fusion <input type="radio"/> (5) Joint Replacement <input type="radio"/> (6) Other	DC ONLY Anticipated CMT Level <input type="radio"/> 98940 <input type="radio"/> 98942 <input type="radio"/> 98941 <input type="radio"/> 98943	Current Functional Measure Score Neck Index <input type="text"/> DASH <input type="text"/> <input type="text"/> <input type="text"/> Back Index <input type="text"/> LEFS <input type="text"/> (other) <input type="text"/>

Patient Completes This Section:

Symptoms began on: <input type="text"/>	Indicate where you have pain or other symptoms: 
1. Briefly describe your symptoms: <input type="text"/>	
2. How did your symptoms start? <input type="text"/>	
3. Average pain intensity: Last 24 hours: no pain <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 worst pain Past week: no pain <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 worst pain	
4. How often do you experience your symptoms? <input type="radio"/> (1) Constantly (76%-100% of the time) <input type="radio"/> (2) Frequently (51%-75% of the time) <input type="radio"/> (3) Occasionally (26% - 50% of the time) <input type="radio"/> (4) Intermittently (0%-25% of the time)	
5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework) <input type="radio"/> (1) Not at all <input type="radio"/> (2) A little bit <input type="radio"/> (3) Moderately <input type="radio"/> (4) Quite a bit <input type="radio"/> (5) Extremely	
6. How is your condition changing, since care began at this facility? <input type="radio"/> (0) N/A — This is the initial visit <input type="radio"/> (1) Much worse <input type="radio"/> (2) Worse <input type="radio"/> (3) A little worse <input type="radio"/> (4) No change <input type="radio"/> (5) A little better <input type="radio"/> (6) Better <input type="radio"/> (7) Much better	
7. In general, would you say your overall health right now is... <input type="radio"/> (1) Excellent <input type="radio"/> (2) Very good <input type="radio"/> (3) Good <input type="radio"/> (4) Fair <input type="radio"/> (5) Poor	

Patient Signature: X

Date: _____