

# Patient Summary Form

PSF-750 (Rev:12/11/2013)

## Instructions

Please complete this form within the specified timeframe. All PSF submissions should be completed online at [www.myoptumhealthphysicalhealth.com](http://www.myoptumhealthphysicalhealth.com) unless otherwise instructed.

Please review the Plan Summary for more information.

## 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			
<input type="text"/>			<input type="text"/>			
Patient address			City		State Zip code	
<input type="text"/>			<input type="text"/>		<input type="text"/>	
Patient insurance ID#		Health plan		Group number		
<input type="text"/>		<input type="text"/>		<input type="text"/>		
Referring physician (if applicable)		Date referral issued (if applicable)		Referral number (if applicable)		
<input type="text"/>		<input type="text"/>		<input type="text"/>		

## Provider Information

<input type="text"/>					<input type="text"/>				
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
<input type="text"/>					<input type="text"/>		<input type="text"/>		<input type="text"/>

## Provider Completes This Section:

Date you want **THIS** submission to begin:

<input type="text"/>	<input type="text"/>	<input type="text"/>
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### Patient Type

- ☐ (1) New to your office  
☐ (2) Est'd, new injury  
☐ (3) Est'd, new episode  
☐ (4) Est'd, continuing care

### Cause of Current Episode

- ☐ (1) Traumatic ☐ (4) Post-surgical  
☐ (2) Unspecified ☐ (5) Work related  
☐ (3) Repetitive ☐ (6) Motor vehicle

### Date of Surgery

<input type="text"/>	<input type="text"/>	<input type="text"/>
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### Type of Surgery

- ☐ (1) ACL Reconstruction  
☐ (2) Rotator Cuff/Labral Repair  
☐ (3) Tendon Repair  
☐ (4) Spinal Fusion  
☐ (5) Joint Replacement  
☐ (6) Other

### Diagnosis (ICD code)

Please ensure all digits are entered accurately

1°	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2°	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3°	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4°	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## Nature of Condition

- ☐ (1) Initial onset (within last 3 months)  
☐ (2) Recurrent (multiple episodes of < 3 months)  
☐ (3) Chronic (continuous duration > 3 months)

### 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)	

## Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

<input type="text"/>	<input type="text"/>	<input type="text"/>
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1. Briefly describe your symptoms:

2. How did your symptoms start?

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?

- ☐ (1) Constantly (76%-100% of the time) ☐ (2) Frequently (51%-75% of the time) ☐ (3) Occasionally (26% - 50% of the time) ☐ (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)

- ☐ (1) Not at all ☐ (2) A little bit ☐ (3) Moderately ☐ (4) Quite a bit ☐ (5) Extremely

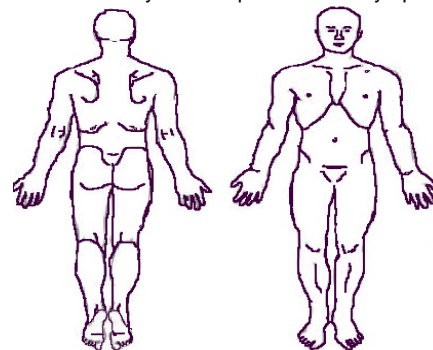
6. How is your condition changing, since care began at **this** facility?

- ☐ (0) N/A — This is the initial visit ☐ (1) Much worse ☐ (2) Worse ☐ (3) A little worse ☐ (4) No change ☐ (5) A little better ☐ (6) Better ☐ (7) Much better

7. In general, would you say your overall health right now is...

- ☐ (1) Excellent ☐ (2) Very good ☐ (3) Good ☐ (4) Fair ☐ (5) Poor

Indicate where you have pain or other symptoms:



Patient Signature: X

Date: \_\_\_\_\_

## The STarT Back Musculoskeletal Screening Tool

Patient name: \_\_\_\_\_ Date: \_\_\_\_\_

Thinking about the **last 2 weeks** tick your response to the following questions:

	Disagree 0	Agree 1
1 My pain has <b>spread</b> at some time in the past 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
2 In addition to my main pain, I have had <b>pain elsewhere</b> in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
3 In the last 2 weeks, I have only <b>walked short distances</b> because of my pain	<input type="checkbox"/>	<input type="checkbox"/>
4 In the last 2 weeks, I have <b>dressed more slowly</b> than usual because of my pain	<input type="checkbox"/>	<input type="checkbox"/>
5 It's really not safe for a person with a condition like mine to be physically active	<input type="checkbox"/>	<input type="checkbox"/>
6 <b>Worrying thoughts</b> have been going through my mind a lot of the time in the last 2 weeks	<input type="checkbox"/>	<input type="checkbox"/>
7 I feel that <b>my pain is terrible</b> and that <b>it's never going to get any better</b>	<input type="checkbox"/>	<input type="checkbox"/>
8 In general in the last 2 weeks, I have <b>not enjoyed</b> all the things I used to enjoy	<input type="checkbox"/>	<input type="checkbox"/>

9. Overall, how **bothersome** has your pain been in the last 2 weeks?

Not at all

☐

0

Slightly

☐

0

Moderately

☐

0

Very much

☐

1

Extremely

☐

1