RRS CARE AUTHORIZATION: Treatment Plan

PATIENTôS NAME:_____ DX: _____

PROVIDER: _____ _____

START DATE: _____ _____

Condition: We will need some information about your patient and the circumstances related to the injury/ condition.

1. Is this authorization request for a new episode or continuation of care?
   ____New ____Continuation
2. Is this a new or recurring condition? _ _New _____Recurring
3. What type of injury or condition is the request related to? _ _Work _ _Auto _ _Other
4. What is the initial date of injury or onset of condition? _____
5. What is the initial date you began treating this patient for this episode of care? _____
6. How many treatments (visits) have you, or anyone on your faculty, provided to this patient over the past 6 months for any diagnosis? _____Times

Treatment: Next we will need some information about the diagnosis and proposed treatment plan:

1. How many visits are being requested (including evaluation)? _____Times
2. How many weeks will it take to complete the requested visits? _____Weeks
3. What is the first (primary) ICD-9 diagnosis code? _____
4. What is the second ICD-9 diagnosis code? _____
5. What is the third ICD-9 diagnosis code?_____
6. Rate the restriction to performing activities of daily living (ADL)? _____(1-10)
7. What is the patientôs average rating of pain over the past two weeks?_____ (1-10)
8. Rate the % of reduction in range of motion for primary diagnosis. _____
9. Does this patient perform moderately intense exercise 3 times per weeks? ____Yes _ _No
10. Is this patientôs MD/DO currently co-treating the condition? _ _Yes _ _No
11. Patientôs most recent functional rating index (FRI) score? _____(1-10)

History: Finally, we will need some historical information about the patient:

1. Does the patient have a history of diabetes? _ _Yes _ _No
2. Does the patient have a history of stroke? _ _Yes _ _No
3. Does the patient have a history of cancer? _ _Yes _ _No
4. Does the patient smoke or use tobacco products? _ _Yes _ _No
5. Is the patient overweight or obese? _ _Yes _ _No
6. Does the patient have a history of chronic pain for > than 6 months? _ _Yes _ _No
7. Does the patient currently have significant issues with depression or anxiety? _ _Yes _ _No