**PRIOR AUTHORIZATION PRESCRIPTION REQUEST FORM FORLUMBAR ORTHOSIS**

**PLEASE SEND THIS FORM BACK IN 3 BUSINESS DAYS**

|  |  |
| --- | --- |
| Date: {date} |  |
| First: {first\_name} Last: {last\_name} | Physician Name: {physician\_name} |
| DOB: {dob} | NPI: {npi} |
| Address: {address} | Address: {physician\_address} |
| City: {city} | City: {physician\_city} |
| State: {state} | State: {physician\_state} |
| Postal Code: {postal\_code} | Postal Code: {physician\_postal\_code} |
| Patient Phone Number: {patient\_phone\_number} | Phone Number: {physician\_phone\_number} |
| Primary Ins: {primary\_insurance} Policy #: {ppn1} | Fax Number: {physician\_fax\_number} |
| Private Ins: {private\_insurance} Policy #: {ppn2} |  |
| Height: {height} |  |
| Weight: {weight} |  |

*This patient is being treated under a comprehensive plan of care for back pain.*

*I, the undersigned; certify that the prescribed orthosis is medically necessary for the patient 's overall well-being. In my opinion, the following back orthosis products are both reasonable and necessary in reference to treatment of the patient 's condition and/or rehabilitation. My patient has been in my care regarding the diagnosis below. This is the treatment I see fit for this patient at this time. I certify that this information is true and correct.*

*This patient is being treated under a comprehensive plan of care for back pain.*

**DIAGNOSIS:** Provider can simply cut off the diagnosis which they don't find appropriate

{diagnosis}

***Our evaluation of the above patient has determined that providing the following back pain orthosis product will benefit this patient:***

**DISPENSE:**

1.0651 - Lumbar-sacral orthosis, Sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to t-9 vertebra, produces intracavitary pressure to reduce load on the Intervertebral discs,

includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated, off-

the—shelf

Length of need is 99 months unless otherwise specified: \_\_\_\_\_\_6 - 99 (99= LIFETIME)

|  |  |
| --- | --- |
| **Physician Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Date Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Physician’s Name: {physician\_name}** | **NPI: {npi}** |

**{first\_name}, {last\_name} {middle\_initial} MRN:{mrn}**

|  |  |
| --- | --- |
|  | |
| **Office Visit** {office\_visit} | Provider: {provider\_name} |
| {provider\_address} | Primary Diagnosis: {primary\_diagnosis} |
|  | Reason for Visit: {reason\_for\_visit} |

**Progress Notes {provider\_name}**

|  |
| --- |
|  |

**Assessment/Plan:**

**{assessment\_plan}**

**Assessment**

Diagnoses and all orders for this visit: {diagnosis\_order}

{assessment\_title}

**Subjective:**

**Chief Complaint**

Patient presents with

* {chief\_complaint\_title}

{chief\_complaint\_detail}

**Subjective**

**Patient ID:** {first\_name} {middle\_initial} {last\_name} with uuid and other detail

**{chief\_complaint\_title}**

{chief\_complaint\_description}

**Objective:**

**Vitals:**

{date\_time}

BP: {bp}

BP Location: {bp\_location}

Patient Position: {patient\_position}

Cuff Size: {cuff\_size}

Pulse: {pulse}

Temp: {temp}

TempSrc: {temp\_src}

Sp02: {sp\_02}

Weight: {weight}

Height: {height}

**Objective**

**Physical Exam**

**{physical\_exam}**

**Instructions**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

After Visit Summary (Automatic Snapshot taken {date})

**Additional Documentation**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Vitals: | BP {bp} (BP Location: {bp\_location}, Patient Position: {patient\_position}, Cuff Size:{cuff\_size}) Pulse {pulse} Temp {temp}F ({temp\_converted\_to\_c}C) (Tympanic) Ht {height} ({height\_in\_meter}m) Wt {weight}kg (weight\_in\_pound\_oz) sp02 BMI {bmi} kg/rnz BSA {bsa} |
| SmartForms | SLAMB SF PHQ-9 |

**Communications**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Orders Placed |
| MRI brain w wo contrast |

|  |
| --- |
| Medication Changes  As of 8/5/2024 2:08 PM |
| None |

|  |  |  |  |
| --- | --- | --- | --- |
| Medication List at End Of Visit  As of 8/5/2024 2:08 PM |  |  |  |
|  | Refills | Start Date | End Date |
| {medication\_list\_title} {medication\_list\_description} | {medication\_list\_refills} | {medication\_list\_start\_date} | {medication\_list\_end\_date} |

**Visit Diagnosis**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary: **{assessment\_title}**

{visit\_detail}

**{first\_name}, {last\_name} {middle\_initial} MRN:{mrn}**

|  |  |
| --- | --- |
|  | |
| **Office Visit** {office\_visit} | Provider: {provider\_name} |
| {provider\_address} | Primary Diagnosis: {primary\_diagnosis} |
|  | Reason for Visit: {reason\_for\_visit} |

**Progress Notes {provider\_name}**

|  |
| --- |
|  |

**Assessment and Plan:**

**{assessment\_plan\_2}**

**Problem List items Addressed This Visit**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

{problem\_list\_items}

**BMI Counseling:** {bmi\_counseling}

**Depression Screening and Follow-up Plan:** {depression\_screening}

{depression\_detail}

**History of Present Illness:**

Patient presents for a Medicare Wellness Visit

HPI

Patient Care Team:

{doctors\_name\_with\_title}

**Review of Systems:**

Review of Systems

Constitutional: {ros2\_constitutional}

HENT: {ros2\_hent}

Eyes: {ros2\_eyes}

Respiratory: {ros2\_respiratory}

Cardiovascular: {ros2\_cardiovascular}

Gastrointestinal: {ros2\_gastrointestinal}

Musculoskeletal: {ros2\_musculoskeletal}

Neurological: {ros2\_neurological}

Psychiatric/Behavioral: {ros2\_psychiatric}

**Problem List:**

Patient Active Problem List

Diagnosis

{patient\_active\_diagnosis}

**Past Medical and Surgical History:**

**Past Medical History:**

|  |  |
| --- | --- |
| Diagnosis | Date |
| * {past\_medical\_diagnosis} | {past\_medical\_date} |

**Past Surgical History:**

|  |  |  |
| --- | --- | --- |
| **Procedure** | **Laterality** | **Date** |
| {past\_surgical\_procedure} | {past\_surgical\_laterality} | {past\_surgical\_date} |

**Family History:**

**Family History**

|  |  |  |
| --- | --- | --- |
| Problem | Relation | Age of Onset |
| * **{problem}** | **{relation}** | **{age\_of\_onset}** |

**Social History:**

**Social History**

Socioeconomic History

|  |  |
| --- | --- |
| * Marital status: | {marital\_status} |
| Spouse name: | {spouse\_name} |
| * Number of children: | {no\_of\_children} |
| * Years of education: | {years\_of\_education} |
| * Highest education level: | {highest\_education} |

Occupational History

|  |  |
| --- | --- |
| * {occupational\_history} |  |

Tobacco Use

|  |  |
| --- | --- |
| * Smoking Status | {smoking\_status} |
| Passive Exposure | {passive\_exposure} |
| * Smokeless Tobacco | {smokeless\_tobacco} |

Vaping Use

|  |  |
| --- | --- |
| * Vaping Use | {vaping\_use} |

Substance and Sexual Activity

|  |  |
| --- | --- |
| * Alcohol Use | {alcohol\_use} |
| * Drug Use | {drug\_use} |
| * Sexual Activity | {sexual\_activity} |

Other Topics Concern

|  |  |
| --- | --- |
| * {other\_topics} | {concern} |

Social History Narrative

{history\_narrative}

**Social Determinants of Health:**

Financial Resource Strain: Low Risk {social\_date})

Overall Financial Resource Strain CARDIA)

* + - Difficulty of Paying Living Expenses: {difficulty\_in\_paying\_living\_expenses}

Food Insecurity: {food\_insecurity}

Transportation Needs: {transportation\_needs}

PREPARE - Transportation

* + - Lack of Transportation (Medical): {lack\_of\_transportation\_medical}
    - Lack of Transportation (Non-Medical): {lack\_of\_transportation\_non\_medical}

Physical Activity: {physical\_activity}

Stress: {stress}

Social Connections: {social\_connections}

Intimate Partner Violence: {intimate\_partner\_violence}

Housing Stability: {housing\_stability}

**Medication and Allergies:**

**Current Outpatient Medications**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication | Sig | Dispense | Refill |
| {current\_outpatient\_medication} | {current\_outpatient\_sig} | {current\_outpatient\_dispense} | {current\_outpatient\_refill} |

{facility\_administered}

**Allergies**

|  |  |
| --- | --- |
| Allergen | Reactions |
| {allergen} | {reactions} |

**Immunizations:**

{immunization}

**Health Maintenance:**

|  |  |
| --- | --- |
| Topic | Due date |
| * {health\_maintenence\_topic} | {health\_maintenence\_due\_date} |

**Medicare Screening Tests and Risk Assessments:**

{medicare\_screening}

**Health RISK Assessment:**

{health\_risk\_assessment}

**Depression Screening:**

PHQ-2 Score: {phq\_score}

PHO-9 Score: {pho\_score}

**Fall Risk Screening:**

In the past year, patient has experienced: **{experience}**

**Urinary Incontinence Screening:**

{urinary\_screening}

**Home Safety**:

{home\_safety}

**Nutrition:**

{nutrition}

**Medications:**

{medications}

**Activities of Daily Living (ADLs)/Instrumental Activities of Daily Living (IADLs):**

Walk and transfer into and out of bed and chair?: **{walk\_and\_transfer}**

Dress and groom yourself?: **{dress\_and\_groom}**

Bathe or Shower yourself?: **{bathe\_or\_shower}**

Feed yourself? **{feed\_yourself}**

Do your laundry/housekeeping?: **{laundry}**

Manage your money, pay your bills and track your expenses?: **{manage\_money}**

Make your own meals?: **{make\_meals}**

Do your own shopping?: **{do\_shopping}**

**Previous Hospitalizations:**

Any hospitalizations or ED visits within the last 12 months?: **{previous\_hospitalization}**

**Advance Care Planning:**

Living will: {living\_will}

Durable POA for healthcare; {durable\_poa}

Advanced directive: {advance\_directive}

Provider agrees with end-of-life decisions: {end\_of\_life\_decisions}

**Cognitive Screening:**

Provider or family/friend/caregiver concerned regarding cognition?: {cognitive\_screening}

**PREVENTIVE SCREENINGS**

**Cardiovascular, Screening:**

General: **{cardiovascular}**

**Diabetes Screening:**

General: **{diabetes}**

**Colorectal Cancer Screening:**

General: **{colorectal}**

**Cancer Screening**

General: **{cancer\_screening}**

**Cervical Cancer Screening:**

General: **{cervical\_cancer}**

**Osteoporosis Screening:**

General: **{osteoporosis\_screening}**

**Abdominal Aortic Aneurism (AAA) Screening:**

General: **{aaa\_screening}**

**Lung Cancer Screening:**

General: **{lung\_cancer\_screening}**

**Hepatitis C Screening;**

General: **{hepatitis\_c\_screening}**

**Screening, Brief Intervention, and Referral to Treatment (SBIRT)**

Screening

**Single Item Drug Screening:**

How often have you used an illegal drug (including marijuana) or a prescription medication for non-

medical reasons in the past year? {single\_item\_drug\_screening}

Single Item Drug Screen Score: {single\_item\_drug\_screening\_score}

Interpretation:{interpretation}

{screening\_results}

**Physical Exam:**

{physical\_exam\_description}

**Physical-Exam**

**Eyes:**

{eyes}

**Neck:**

{neck}

**Cardiovascular:**

{cardiovascular}

**Pulmonary:**

{pulmonary}

**Abdominal:**

{abdominal}

**Musculoskeletal:**

{musculoskeletal}

**Lymphadenopathy:**

{lymphadenopathy}

**Neurological:**

{neurological}

**Psychiatric:**

Behavior: {psychiatric\_behaviour}.

{provider\_name}

**Instructions**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medicare Preventive Visit Patient Instructions**

Thank you for completing your Welcome to Medicare Visit or Medicare Annual Wellness Visit today. Your

next wellness visit will be due in one year ({date\_after\_one\_year}).

The screening/ preventive services that you may require over the next 5-10 years are detailed below

Some tests may not apply to you based off risk factors and/or age. Screening tests ordered at today's visit

but not completed yet may show as past due. Also, please note that scanned in results may not display

below.

Preventive Screenings:

|  |  |  |
| --- | --- | --- |
| **Service** | **Recommendations** | **Previous Testing/Comments** |
| **{service}** | **{preventive\_recommendations}** | **{previous\_testing}** |

Other Preventive Screenings Covered by Medicare:

{other\_preventive\_screening}

*Immunizations:*

|  |  |
| --- | --- |
| **Immunization** | **Recommendations** |
| {immunization} | {immunization\_recommendations} |

**Health Maintenance Due:**

|  |  |
| --- | --- |
| Topic | Due Date |
| * {health\_maintenance\_topic\_2} | {health\_maintenence\_due\_date\_2} |

**Immunization Due:**

|  |  |
| --- | --- |
| Topic |  |
| * {immunization\_due\_topic} | {immunization\_due\_due\_date} |

**Advance Directives**

**What are advance directives?** Advance directives are legal documents that state your wishes and plans

for medical care. These plans are made ahead of time in case you lose your ability to make decisions for

yourself. Advance directives can apply to any medical decision, such as the treatments you want, and if

you want to donate organs.

**What are the types of advance directives?** There are many types of advance directives, and each state

has rules about how to use them. You may choose a combination of any of the following:

* + - **Living will:** This is a written record of the treatment you want. You can also choose which treatments you do not want, which to limit, and which to stop at a certain time. This includes surgery, medicine, IV fluid, and tube feedings.
    - **Durable power of attorney for healthcare (DPAHC):** This is a written record that states who you want to make healthcare choices for you when you are unable to make them for yourself. This person, called a proxy, is usually a family member or a friend. You may choose more than 1 proxy.
    - **Do not resuscitate (DNR) order:** A DNR order is used in case your heart stops beating or you stop breathing. It is a request not to have certain forms of treatment, such as CPR. A DNR order may be included in other types of advance directives.
    - **Medical directive:** This covers the care that you want if you are in a coma, near death or unable to make decisions for yourself. You can list the treatments you want for each condition. Treatment may include pain medicine, surgery, blood transfusions, dialysis, IV or tube feedings, and a ventilator (breathing machine).
    - **Values history:** This document has questions about your views, beliefs, and how you feel and think about life. This information can help others choose the care that you Would choose.

**Why are advance directives Important?** An advance directive helps you control your care. Although

spoken wishes may be used, it is better to have your wishes written down. Spoken wishes can be

misunderstood, or not followed. Treatments may be given even if you do not want them. An advance

directive may make it easier for your family to make difficult choices about your care.

**Urinary Incontinence**

Urinary Incontinence WI) is when you lose control of your bladder. UI develops because your bladder

cannot store or empty urine properly. The 3 most common types of UI are stress incontinence, urge

incontinence, or both.

Medicines:

* May be given to help strengthen your bladder control. Report any side effects of medication to your healthcare provider,

**Do pelvic muscle exercises often:** Your pelvic muscles help you Stop urinating. Squeeze these muscles

tight for 5 seconds. then relax for 5 seconds. Gradually work up to squeezing for 10 seconds. Do 3 sets of

15 repetitions a day, or as directed. This will help strengthen your pelvic muscles and improve bladder

control.

**Train your bladder:** Go to the bathroom at set times, such as every 2 hours, even if you do not feel the

urge to go. You can also try to hold your urine when you feel the urge to go. For example, hold your urine

for 5 minutes when you feel the urge to go. AS that becomes easier, hold your urine for 10 minutes.

**Self-care:**

* **Keep a UI record:** Write down how often you leak urine and how much you leak. Make a note of what you were doing when you leaked urine.
* **Drink liquids as directed.** You may need to limit the amount of liquid you drink to help control your urine leakage. Do not drink any liquid fight before you go to bed. Limit or do not have drinks that contain caffeine or alcohol.
* **Prevent constipation**. Eat a variety of high-fiber foods. Good examples are high-fiber cereals, beans, vegetables, and. whole-grain breads. Walking is the best way to trigger your intestines to have a bowel movement.
* **Exercise regularly and maintain a healthy weight**. Weight loss and exercise will decrease pressure on your bladder and help you control your leakage.
* **Use a catheter as directed** to help empty your bladder. A catheter is a tiny, plastic tube that is put into your bladder to drain your urine.
* **Go to behavior therapy as directed.** Behavior therapy may be used to help you learn to control your urge to urinate.

**Weight Management**

**Why it important to manage your weight:** Being overweight increases your risk of health conditions

such as heart disease, high blood pressure, type 2 diabetes, and certain types of cancer. It can also

increase your risk for osteoarthritis, sleep apnea, and other respiratory problems. Aim for a slow, steady

weight loss. Even a small amount of weight loss can lower your risk of health problems.

**How to lose weight safely:** A safe and healthy way to lose weight is to eat fewer calories and get regular

exerciser You can lose up about 1 pound a week by decreasing the number of calories you eat by 500

calories each day.

**Healthy meal plan for weight management:** A healthy meal plan includes a variety of foods, contains

fewer calories, and helps you stay healthy- A healthy meal plan includes the following:

* **Eat whole-grain foods more often.** A healthy meal plan should contain fiber. Fiber is the part of grains, fruits, and vegetables that is not broken down by your body. Whole-grain foods are healthy and provide extra fiber in your diet. Some examples of whole-grain foods are whole-wheat breads and pastas, oatmeal, brown rice, and bulgur.
* **Eat a variety of vegetables every day.** Include dark, leafy greens such as spinach, kalo, collard greens, and mustard greens. Eat yellow and orange vegetables such as carrots, sweet potatoes, and winter squash.
* **Eat a variety of fruits every day.** Choose fresh or canned fruit (canned in its own juice or light syrup) instead of juice. Fruit juice has very little or no fiber.
* **Eat low-fat dairy foods.** Drink fat-free (skim) milk or 1% milk. Eat fat-free yogurt and low-fat cottage cheese, Try low-fat cheeses such as mozzarella and other reduced-fat cheeses.
* **Choose meat and other protein foods that are low in fat.** Choose beans or other legumes such as split peas or lentils. Choose fish, skinless poultry (chicken or turkey). or lean cuts of red meat (beef or pork). Before you cook meat or poultry cut off any visible fat.
* **Use less fat and Oil.** Try baking foods instead of frying them. Add less fat, Such as margarine. Sour cream, regular salad dressing and mayonnaise to foods. Eat fewer high-fat foods. Some examples of high-fat foods include french fries, doughnuts, ice cream, and cakes.
* **Eat fewer sweets.** Limit foods and drinks that are high in sugar. This includes candy, cookies, regular soda, and sweetened drinks.

**Exercise:** Exercise at least 30 minutes per day on most days of the week. Some examples of exercise Include walking, biking, dancing, and swimming. You can also fit in more physical activity by taking the stairs instead of the elevator or parking farther away from stores. Ask your provider about the best exercise plan for you.

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**Additional Documentation**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SmartForms: SL AMB SF PHQ-9

|  |
| --- |
| Orders Placed |
| {orders\_placed\_2} |

|  |
| --- |
| Medication Changes  As of {medication\_changes\_2} 2:08 PM |
| None |

|  |  |  |  |
| --- | --- | --- | --- |
| Medication List at End Of Visit  As of 8/5/2024 2:08 PM |  |  |  |
|  | Refills | Start Date | End Date |
| {medication\_2} | {refills\_2} | {start\_date\_2} | {end\_date\_2} |

**Visit Diagnosis**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary: **{visit\_diagnosis\_2}**

{visit\_diagnosis\_2\_details}