ICD-10 Compatible

PT/OT Treatment Form
(version 2.1)
www.palladianhealth.com/providers

Palladian

18650

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

Specialty: ○ PT ○ OT

NPI

Section A. Provider information

First name

Last name

Facility name: PROHEALTH & Fitness

Service Street Address: 180 WEST END AVE

NEW YORK NY 10023

Section B. Patient information

First name

Last name

Health plan: EMBLEM

Member ID

Date of Birth (MM-DD-YYYY)

Onset

Last visit

Requested start

Surgical/ Fracture

Section C. Primary region of complaint (select only 1 region)

Spine
- ○ Cervical
- ○ C/S+radiculopathy
- ○ Thoracic
- ○ Lumbosacral
- ○ L/S+radiculopathy

Upper extremity
- Shoulder ○ L ○ R
- Elbow ○ L ○ R
- Wrist ○ L ○ R
- Hand ○ L ○ R

Lower extremity
- Hip ○ L ○ R
- Knee ○ L ○ R
- Ankle ○ L ○ R
- Foot ○ L ○ R

Other (also indicate region)
- ○ Post-surgical
- ○ Fracture
- ○ Other

Rehabilitation
- ○ Stroke
- ○ Spinal cord
- ○ Neurological
- ○ Balance/coordination

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Section D. Red flags (i.e. signs or symptoms that may indicate potentially serious pathology)

Does this patient have any red flags (e.g. "yes" answers to PT/OT Patient Intake Form questions 6-20)? ○ No ○ Yes

Does this patient have any contraindications to receiving PT/OT care from you for this complaint? ○ No ○ Yes

Section E. Evaluation

Based on information provided by the patient, your examination, and your treatment history with this patient (if any), what is your evaluation of this patient's primary region of complaint? Please choose one box for each of these columns.

Symptoms
- ○ Very mild
- ○ Mild
- ○ Moderate
- ○ Severe
- ○ Very severe

Physical function
- ○ Very good
- ○ Good
- ○ Moderate
- ○ Poor
- ○ Very poor

Overall health
- ○ Very good
- ○ Good
- ○ Moderate
- ○ Poor
- ○ Very poor

Prognosis
- ○ Very good
- ○ Good
- ○ Moderate
- ○ Poor
- ○ Very poor

Section F. Management plan (i.e. how you plan on managing this patient's complaint)

Education about:	○ Diagnosis	○ Prognosis	○ Remaining active	○ Other	○ None
Home/self-care:	○ Heat/ice	○ General exercises	○ Specific exercises	○ Other	○ None
Supervised exercise:	○ Strengthening	○ Stretching	○ Stabilization	○ Other	○ None
Modalities:	○ Heat/ice	○ TENS/EMS	○ Ultrasound	○ Other	○ None
Manual therapy:	○ Manipulation	○ Mobilization	○ Soft tissue	○ Other	○ None

Number of PT/OT visits used since last PT/OT Treatment Form was submitted:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ Other

Phone 212-600-4781 Fax 800-655-3780

Provider signature: X Date MM / DD / YYYY

18650

V:PalladianPTOTtreatment(2.1)20150901

Note: By completing and signing this form below, the provider indicates that they:
1. provided/supervised all PT/OT services, and 2. are a participating PT/OT provider, and 3. provided all PT/OT services in a credentialed practice.

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PT/OT Patient Intake Form
(version 1.5)
www.palladianhealth.com/members

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Last name		First name	

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

1. Why are you here today? If there are many reasons, please choose only the most important or most severe one.

O Neck	O Shoulder	O Hip	O Stroke rehabilitation	**Other (also indicate region)**
O Upper/ mid-back	O Elbow	O Knee	O Spinal cord rehabilitation	O Post-surgical
O Lower back	O Wrist	O Ankle	O Neurologic rehabilitation	O Fracture
	O Hand	O Foot	O Balance/coordination	O Other

2. When did this problem first begin?
O Less than 1 month ago O 1-3 months ago O 4-6 months ago O 7-12 months ago O More than 1 year ago

	Has this problem...	**No**	**Yes**
3.	... resulted from a work injury (i.e. workers' compensation insurance claim)?	O	O
4.	... resulted from a motor vehicle accident (i.e. no fault insurance claim)?	O	O
5.	... recently been evaluated by a medical doctor?	O	O
	Since this problem began, have you noticed...	**No**	**Yes**
6.	... so much weakness in both your arms that you are unable to lift them?	O	O
7.	... so much weakness in both your legs that you are unable to walk without help?	O	O
8.	... difficulty controlling your bowel or bladder, or have you been unable to urinate?	O	O
9.	... pain in your chest, shortness of breath, or coughing up blood?	O	O
10.	... that one leg felt more warm, more swollen, more red, or more tender than the other?	O	O
	Have you recently...	**No**	**Yes**
11.	... had blurred vision, double vision, dizziness, or fainting?	O	O
12.	... had any type of infection, fever, or chills?	O	O
13.	... had any type of surgery, surgical procedure, or medical procedure?	O	O
14.	... lost a lot of weight without really trying to (i.e without being on a diet)?	O	O
15.	... had any type of accident, fall, or trauma?	O	O
	Have you ever...	**No**	**Yes**
16.	... been diagnosed with cancer?	O	O
17.	... been diagnosed with osteoporosis (i.e. weak, soft, or brittle bones)?	O	O
18.	... been diagnosed with a weakened immune system?	O	O
19.	... used any injected drugs (i.e. non-prescription drugs)?	O	O
20.	... used steroids such as prednisone for more than 4 weeks?	O	O
	Is this problem something that ...	**No**	**Yes**
21.	... you've had before?	O	O
22.	... generally gets worse (i.e more severe or frequent) with movement, activity, or exercise?	O	O
23.	... generally gets better (i.e. less severe or frequent) with rest?	O	O
24.	... was recently examined with diagnostic imaging tests such as x-rays, MRI scan, or CT scan?	O	O
25.	... is also being treated by a health professional other than a physical or occupational therapist?	O	O

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PT/OT Patient Outcomes Form (version 1.5)

www.palladianhealth.com/members

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Last Name | First name

PLEASE COMPLETELY FILL IN THE ONE CIRCLE THAT BEST DESCRIBES YOUR ANSWER. (Example: ●)

	Excellent	Very good	Good	Fair	Poor
1. In general, would you say your health is	O	O	O	O	O

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	O	O	O
3. Climbing several flights of stairs	O	O	O

During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
4. Accomplished less than you would like	O	O	O	O	O
5. Were limited in the kind of work or other activities	O	O	O	O	O

During the past week, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
6. Accomplished less than you would like	O	O	O	O	O
7. Did work or other activities less carefully than usual	O	O	O	O	O

	Not at all	A little bit	Moderately	Quite a bit	Extremely
8. During the past week, how much did pain interfere with your normal work (including work outside the home and housework)?	O	O	O	O	O

These questions are about how you feel and how things have been with you during the past week. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past week...	All of the time	Most of the time	Some of the time	A little of the time	None of the time
9. Have you felt calm and peaceful?	O	O	O	O	O
10. Did you have a lot of energy?	O	O	O	O	O
11. Have you felt downhearted and depressed?	O	O	O	O	O

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
12. During the past week, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?	O	O	O	O	O

How would you rate the severity of your main problem on a scale from 0 (not severe) to 10 (worst imaginable)?

	Not severe	0	1	2	3	4	5	6	7	8	9	10	Worst imaginable
13. Right now		O	O	O	O	O	O	O	O	O	O	O	
14. On average		O	O	O	O	O	O	O	O	O	O	O	
15. At its best		O	O	O	O	O	O	O	O	O	O	O	
16. At its worst		O	O	O	O	O	O	O	O	O	O	O	