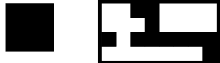

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PT/OT Treatment Form
(version 1.5)
www.palladianhealth.com/providers

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

Specialty: O PT O OT
Location: O Office O Facility

Provider ID

Section A. Provider information

First name
Last name
Facility name

Service Street Address

Check if
O Workers' compensation injury O No-fault injury

Section B. Patient information

First name
Last name
Health plan
Member ID

Date of	M M	D D	Y Y Y Y
Birth	-	-	
Onset	-	-	
Last visit	-	-	
Requested start	-	-	

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

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

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

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

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

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

Primary ICD-9 .

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)? O No O Yes
Does this patient have any contraindications to receiving PT/OT care from you for this complaint? O No O 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	Physical function	Overall health	Prognosis
O Very mild	O Very good	O Very good	O Very good
O Mild	O Good	O Good	O Good
O Moderate	O Moderate	O Moderate	O Moderate
O Severe	O Poor	O Poor	O Poor
O Very severe	O Very poor	O Very poor	O Very poor

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

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

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

Phone - - Fax - -

Provider signature: X

Date / /
MM DD Y Y Y Y

4287

V:PalladianPTOTtreatment(1.5)20100113

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.