NON-SPINE THERAPY PRECERTIFICATION REQUEST

Fax 503-601-8437 or Toll Free 888-353-5920

Facility Name:______________________________ Phone:____________________

Type of Therapy (Circle One): Physical Therapy • Occupational Therapy • Aquatic • Work Hardening • Work Conditioning

Patient Name:______________________________ Diagnosis/ICD10 Code:____________________
Claim#______________________________ Accepted Conditions: ____________________
Date of Injury: ____________________ Attending Physician:____________________
First Date Ever Treated:________________ Total Visits Since Injury:____________________
First Date Treated Since Surgery________________ Total Visits Since Surgery:____________________

TODAY'S PROGRESS INFORMATIONS IS FROM period________________ to ____________________
Number of Visits this period: _________ Number of missed appointments this period: _______________
Current Pain Level (0-10):______________________________

General Physical Requirements of job Classification I, II, III	Recommended Restrictions	Date of Last Exam	Current Exam
	Lift:	_______lbs.	_______lbs.
	Carry:	_______lbs.	_______lbs.
	Other:		
	Other:		

ROM-JOINT Body Area:			MUSCLE STRENGTH:	
Motion	Last Progress Exam L/R	Current Progress Exam L/R	Last Progress Exam L/R	Current Progress Exam L/R
Flexion:	/	/	/	/
Extension:	/	/	/	/
	/	/	/	/
	/	/	/	/
	/	/	/	/

ROM-JOINT Body Area:			MUSCLE STRENGTH:	
Motion	Last Progress Exam L/R	Current Progress Exam L/R	Last Progress Exam L/R	Current Progress Exam L/R
Flexion:	/	/	/	/
Extension:	/	/	/	/
	/	/	/	/
	/	/	/	/
	/	/	/	/

Proposed Treatment Dates for Majoris Review:

Dates: From: ___________To: ___________Frequency: ________________ Total Treatments: _________

Brief narrative of progress to date & functional/objective limitation to be addressed in proposed treatment period:

____
____
____
____

Likely prognosis of returning to independent, self-management in the proposed treatment period: Likely ☐ Unlikely ☐ Guarded ☐

Likely prognosis of returning to prior occupation in the proposed treatment period: Likely ☐ Unlikely ☐ Guarded ☐ Already Returned ☐

Note, passive treatments will not be reviewed without a completed addendum form.

Therapists Signature:______________________________ Date:____________________

Physician's signature:______________________________ Date:____________________

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