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	Functional Strength	Last Exam Date	Current Date
	Lift	_____lbs.	_____lbs.
	Carry	_____lbs.	_____lbs.
	Other		
	Other		

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	/	/	/	/
Side Bending	/	/	/	/

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:_____

Majoris Health Systems, Inc.
P.O. Box 1728 • Lake Oswego, OR 97035
Phone (503) 639-6080 • Toll Free (800) 525-0394 • Fax 503-601-8437