# Patient Summary Form

PSF-750 (Rev: 7/1/2015)

**Instructions**
Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.

Please review the Plan Summary for more information.

## Patient Information

Patient name: Last | First | MI

◯ Female
◯ Male

Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

## Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)
2. Federal tax ID(TIN) of entity in box #1
3. Name and credentials of the individual performing the service(s)

1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ____

4. Alternate name (if any) of entity in box #1
5. NPI of entity in box #1
6. Phone number
7. Address of the billing provider or facility indicated in box #1
8. City
9. State
10. Zip code

## Provider Completes This Section:

**Date you want *THIS* submission to begin:**

**Patient Type**

1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

**Cause of Current Episode**

1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

**Date of Surgery**

**Type of Surgery**

1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other _____

**Diagnosis (ICD codes)**
*Please ensure all digits are entered accurately*

1°
2°
3°
4°

**Nature of Condition**

1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

**DC ONLY**
**Anticipated CMT Level**

◯ 98940 ◯ 98942
◯ 98941 ◯ 98943

**Current Functional Measure Score**

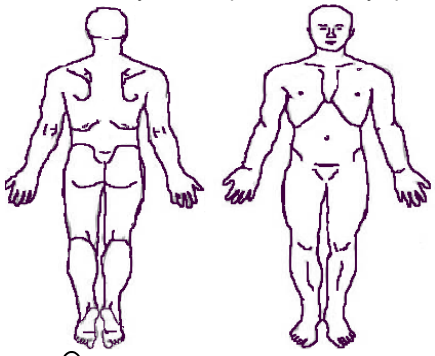
Neck Index | DASH | _____ (other FOM)
Back Index | LEFS

## Patient Completes This Section:

(Please fill in selections completely)

**Symptoms began on:**

Indicate where you have pain or other symptoms:



**1. Briefly describe your symptoms:**

**2. How did your symptoms start?**

**3. Average pain intensity:**

Last 24 hours: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**
Past week: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

**4. How often do you experience your symptoms?**

1. Constantly (76%-100% of the time) 2. Frequently (51%-75% of the time) 3. Occasionally (26% - 50% of the time) 4. Intermittently (0%-25% of the time)

**5. How much have your symptoms interfered with your usual daily activities?** (including both work outside the home and housework)

1. Not at all 2. A little bit 3. Moderately 4. Quite a bit 5. Extremely

**6. How is your condition changing, since care began at *this* facility?**

0. **N/A — This is the initial visit** 1. Much worse 2. Worse 3. A little worse 4. No change 5. A little better 6. Better 7. Much better

**7. In general, would you say your overall health right now is...**

1. Excellent 2. Very good 3. Good 4. Fair 5. Poor

**Patient Signature:** X _____ **Date:** _____