PT/OT
Questionnaire for Faxing Reviews w/ Request Form

1. Date of your initial PT/OT evaluation?
2. # of Scheduled visits from initial evaluation thru expiration of current authorization period?
3. # of Completed visits from initial evaluation thru expiration of current authorization period?
4. # of Cancelled visits from initial evaluation thru expiration of current authorization period?
5. # of No-shows from initial evaluation thru expiration of current authorization period?
6. If patient has had surgery after the date specified in question 1, what was the date of the post-op re–evaluation?
7. How many post-op visits have occurred since the post–op re–evaluation?
8. Was therapy provided on this claim prior to the date of your evaluation? ☐ Yes ☐ No ☐ Unknown
9. If yes, number of visits? If unknown, state unknown.
10. Date of last MD visit? If unknown, state unknown.
11. Date of current prescription for therapy?
12. What did the physician order?
13. When is the patient's next scheduled MD visit? If unknown, state unknown.
14. Is there rehab potential with the expectation for clinical or functional improvement for return to work? ☐ Yes ☐ No
15. Briefly describe any barriers to achieving rehabilitation goals. If none, state 'none'.
16. Describe the patient's therapy program (check all that apply)
    - ☐ Therapeutic Exercise
    - ☐ Manual therapy
    - ☐ Ongoing teaching
    - ☐ Home ex and evaluation of knowledge retention
17. Is there documented progress toward measurable return-to-work goals? ☐ Yes ☐ No
18. Describe patient's progress toward current goals:
    - ☐ Improvement in function
    - ☐ Improved ROM
    - ☐ Documented adherence to home ex program
    - ☐ Improved ambulation
    - ☐ Reduction in limitations
    - ☐ Improved ADLs/IADLs
    - ☐ Reduction in intensity of symptoms
    - ☐ Improved strength
    - ☐ Reduction in frequency of symptoms
19. Has patient demonstrated greater independence in home (self-management) program? ☐ Yes ☐ No
20. Describe patient's current functional status
    - ☐ No functional limitations
    - ☐ Mild limitations
    - ☐ Moderate limitations
    - ☐ Severe limitations
21. If patient has mild limitations, check all that apply
    - ☐ Intermittent symptoms with variable intensity
    - ☐ Symptoms worsen with or after activity or movement
    - ☐ ROM or strength normal or minimally limited
    - ☐ Variable or minimal limitations with ADLs or IADLs

    If patient has moderate limitations, check all that apply
    - ☐ Consistent symptoms with variable intensity
    - ☐ Symptoms present at rest and exacerbated by activity
    - ☐ ROM or strength decreased
    - ☐ Consistent limitations with ADLs or IADLs

    If patient has severe limitations, check all that apply
    - ☐ Consistent frequency and intensity of symptoms
    - ☐ ROM or strength decreased
    - ☐ Muscle atrophy
    - ☐ Unable to complete or participate in ADLs or IADLs
22. What is the patient's current rehabilitation potential?
    - ☐ Good
    - ☐ Fair
    - ☐ Poor
23. What is the current estimated date of discharge?

Patient Name: Claim #