PT/OT Notification Form

ACN Group, Inc. - Form NF-602

Instructions
Complete this form and submit via Web, mail, or fax to ACN Group within 3 days of the initial date of service.
www.acnprovider.com

○ Female ○ Male

Patient s Name (Last, First, MI) | Patient's Date of Birth

Patients Address | City | State | Zip

○ Prim ○ Sec

Patient's Insurance ID# | Health Plan | Group Number

Referral Info (If required by health plan as stated on your Plan Summary.)

○ Yes ○ No

Referred | Referring Doctor | Date Referral Issued | Referral # | Condition referred for

Type of Service

- ○ PT only
- ○ OT only
- ○ Both PT and OT

Nature of Condition

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

Functional Outcome Measure Score

Neck Index | DASH | (other) | (other)

Back Index | LEFS

The date you want this Notification to begin:

Date of Surgery

Cause of Current Episode

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

Type of Surgery

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

Anticipated Treatment Duration (weeks)

○ 4 ○ 6 ○ 8
○ 12 ○ 16 ○ 20

Patient Type

- ① New to Your Office
- ② Est'd, new to ACN Group
- ③ Est'd, new injury
- ④ Est'd, new episode
- ⑤ Est'd, continuing care

Anticipated Status After This Episode

- ① MTB, no residuals, discharged
- ② MTB, residuals, discharged
- ③ MTB, residuals, PRN/supportive care
- ④ Not at MTB, update tx goals/plan
- ⑤ Referred/transferred

Diagnosis

Clinical Primary

Check If Applicable - add comments to the right

○ There are significant co-morbidities/complicating factors that are delaying recovery. Describe _____

Clinic Name | Therapist Name and Specialty | Tax ID

Clinic Address | City | State | Zip

Clinic Phone Number

I declare that the above information is true and accurate to the best of my knowledge. It is my professional judgment that my treatment plan is not contraindicated for this patient. I have discussed the above condition, prognosis following this plan of care, and have established appropriate and realistic goals with the patient.

Therapist Signature | Date

ACN Group Use Only
rev 05/18/06

Effective Date | Reference Number | Overlap

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

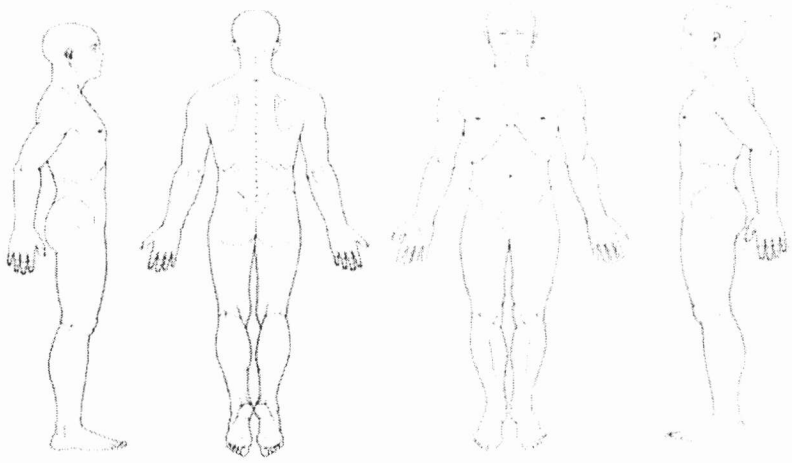
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

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

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (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. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

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

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past?

① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____