**Osteopathic Manipulation Treatment Plan**

**eviCore healthcare**

**FAX (888) 565-4225**

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**Subjective Complaints:**

- Lost days from work to date
- Days of work restriction to date

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**Mechanism of Onset for Primary Diagnosis**

**Date of Onset (MM/DD/YYYY) / / /**

- Acute trauma
- Worsening of prior illness/injury
- Repetitive motion
- Gradual onset
- Chronic
- Old trauma

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**Summary of Examination Findings**

1. Localized pain reproduced on palpation or orthopedic testing (list area)
2. Radiating pain below knee or elbow reproduced on nerve compression or stretch test (list nerve root distribution)
3. Pain referred from muscles or trigger points (list)
4. Diffuse ache on passive motion (list joint/s)
5. Testing revealed pain, swelling or instability of joint or extremity (list)
6. Neurological tests within normal limits
7. Neurological deficits (describe):

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**Objective Findings**

**Date Obtained / / /**

**VITALS:**
- **HT:**
- **WT:**
- **BP:**
- **Temp:**

**Inspection:**

- Flexion
- Extension
- L. Lat. Flex
- R. Lat. Flex
- R. Rotation
- L. Rotation

**Palpation:**

**Bone weakening or destructive disorders (e.g., tumors)**

**Neurological disorders (myelopathy, acute cauda equina syndrome, multiple sclerosis, etc.)**

**Articular derangements (arthritis, autoimmune diseases, joint instability or hypermobility, etc.)**

**History of infection (recent fever >100, constant low-grade fever, bone or joint infection, etc.)**

**Circulatory or cardiovascular disorders (e.g., stroke)**

**Bone weakening or destructive disorders (e.g., tumors)**

**Neurological disorders (myelopathy, acute cauda equina syndrome, multiple sclerosis, etc.)**

**Artrophy in the extremities**

**Abnormal deep tendon reflexes or motor weakness**

**Scoliosis >20 degrees adult or >10 degrees for child**

**Congenital connective tissue disorders**

**Abnormal bowel or bladder function**

**Signs or symptoms of vertebro basilar insufficiency**

**Fever or localized redness and swelling or ankylosing spondylitis**

**Signs or symptoms of cancer or chemotherapy tx**

**Signs or symptoms of organic disease**

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**Complicating Factors**

- Poor tissue healing such as: pernicious anemia, diabetes, thyroid disease
- Other: Anatomical deficit such as: asymmetrical facets, djd, spinal stenosis, spondylolisthesis, congenital or acquired joint anomaly, 3rd trimester pregnancy, >100 lbs. overweight

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**Treatment Plan**

**MM/DD/YYYY**

- **From / / /**
- **To / / /**
- **No. of Visits Requested**

**Comments/Goal of Tx**

- Reduce pain ___ %
- Improve ROM ___ %

**Complicating Factors**

- Poor tissue healing such as: pernicious anemia, diabetes, thyroid disease
- Other: Anatomical deficit such as: asymmetrical facets, djd, spinal stenosis, spondylolisthesis, congenital or acquired joint anomaly, 3rd trimester pregnancy, >100 lbs. overweight

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**Mechanical X-ray Findings**

**WNL**

**Medical X-ray Findings**

- Fracture/Dislocation
- Gross Osseous Pathology
- Pathology as noted

**Date taken / / /**

**Describe X-ray findings:**

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**X-Rays Requested:**

- Yes
- No

**Taken:**

- Yes
- No

- 3 view cervical, CPT 72040 (AP, APOM, LAT)
- 2 view thoracic, CPT 72070 (AP, LAT)
- 2 view lumbar, CPT 72100 (AP, LAT)
- Other ________

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**ICD Code**

- **(list NMS codes only)**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Primary</td>
<td>________</td>
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<tr>
<td>2. Secondary</td>
<td>________</td>
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<tr>
<td>3. Additional</td>
<td>________</td>
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</tbody>
</table>

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**Date of Submission / / /**

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**I declare that the above information is true and correct to the best of my knowledge.**

**Signature** ________________________ **Date** __________________

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**I feel free to submit any and all additional information not included on the Treatment Plan form that you feel is necessary to support the services you are requesting.**