PT/OT Treatment Request Clinical Worksheet
Pelvic Pain/Incontinence Conditions

For NON-URGENT requests, please fax this completed document along with medical records, imaging, tests, etc. If there are any inconsistencies with the medical office records, please elaborate in the comment section. Failure to provide all relevant information may delay the determination. Phone and fax numbers can be found on eviCore.com under the Guidelines and Fax Forms section. You may also log into the provider portal located on the site to submit an authorization request. URGENT (same day) REQUESTS MUST BE SUBMITTED BY PHONE.

Reference/Auth Number: _____ **(if continued care)** ☐ **PT** ☐ **OT** **Date of Submission** **/ /**

RENDERING PROVIDER INFORMATION – All sections must be completed

Therapist Last Name, First Name	Group or Facility Name		Billing Provider TIN
Provider/Group Address, City State Zip Code		Phone ( ) Fax ( )	Billing Provider NPI

PATIENT INFORMATION – All sections must be completed

Patient Last Name, First Name	Date of Birth / /	Mailing Address, City, State Zip Code	
Member ID	Payor Name	Subscriber Last Name, First Name	Phone ( )

CLINICAL INFORMATION

Primary ICD/Diagnosis Code Description	Start date of this request / /

Please indicate which of the following applies:

☐ Additional care req'd for same condition treated in last 60 days ☐ Member requires treatment for a new condition ☐ Member not treated in last 60 days

If the member requires treatment for a new condition, what was the **previous condition?** ☐ Lumbar-Pelvis ☐ Cervical-Thoracic ☐ Shoulder-Arm ☐ Elbow- Wrist-Forearm ☐ Hand ☐ Hip-Thigh ☐ Knee/Thigh ☐ Ankle-Foot-Leg

Status of Previous Treatment: ☐ Condition resolved ☐ Ongoing

Date of initial evaluation / / Date of onset / / Date of current findings / /

Fabricating a splint/orthotic or developing a home exercise program ***only***? ☐ Y ☐ N ***If yes, you are not required to complete remaining fields.***

Primary Dx? ☐ Pelvic Pain ☐ Incontinence

PELVIC PAIN ***Complete if Pelvic Pain is Primary Dx. Patient Specific Functional Scale is also required.***

Pelvic or S.I. joint asymmetry? ☐ Y ☐ N If yes, select all that apply:

☐ Iliac crest height asymmetry? ☐ Pubic symphysis asymmetry? ☐ Sacral torsion noted ☐ Provocative S.I. test noted

Were special tests, e.g. EMG or RUSI performed? ☐ Y ☐ N ***If yes, please enter results in additional information box below.***

Able to perform repetitive contractions of the pelvic floor muscles? ☐ Y ☐ N Able to relax the pelvic floor muscles? ☐ Y ☐ N

Pain level ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Unk Frequency ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% ☐ Unk

Number of incontinence/leakage events per day ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 or more

INCONTINENCE – ***Complete if Incontinence is Primary Dx. Patient Specific Functional Scale required.***

Urinary Symptoms present? ☐ Y ☐ N If Yes, Indicate type: ☐ Stress ☐ Urge ☐ Mixed ☐ Functional ☐ Overactive Bladder

Bowel symptoms present? ☐ Y ☐ N If Yes, Indicate type: ☐ Fecal Incontinence ☐ Pain ☐ Other

Number of incontinence/leakage events per day ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 or more

Indicate structural problems, if present: ☐ None ☐ Prolapse ☐ Perineal Descent ☐ Pelvis or S.I. asymmetry

Were special tests, e.g. EMG or RUSI performed? ☐ Y ☐ N ***If yes, please enter results in additional information box below.***

Able to perform repetitive contractions of the pelvic floor muscles? ☐ Y ☐ N Able to relax the pelvic floor muscles? ☐ Y ☐ N

Pain level ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Unk Frequency ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100% ☐ Unk

Change in condition since start of care: ☐ Much better ☐ Somewhat better ☐ No change ☐ Somewhat or much worse ☐ Unknown change

Additional Information:

Patient Specific Functional Scale: Score 3 activities that the patient has the most difficulty performing. 0 is unable to perform, 10 is no difficulty.

Activity 1:	Level: /10	Activity 3:	Level: /10
Activity 2:	Level: /10	Percent of improvement since start of care:	% ☐ Unknown

Was treatment provided for a second body part? ☐ Y ☐ N Submit a second Treatment Request for the additional area of treatment. Fax both forms together.