

# Employer/Carrier Request to Health Care Provider for Additional Information Regarding Non-Pharmacological Treatment Recommendation

## TO BE COMPLETED BY THE CARRIER/EMPLOYER

Patient Name: _____	Today's Date: _____
Patient ID #: _____	Date of Injury: _____
Employer: _____	Carrier: _____
Treating Provider: _____	IC File #: _____
TO TREATING HEALTH CARE PROVIDER: You recently recommended the following non-pharmacological treatment for pain for the above-named employee: _____	
Your prompt completion and return of this form to the following person is appreciated: Name: _____ Telephone number: _____ Fax number: _____ Email address: _____	

## TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Please provide the following additional information regarding the recommended treatment:

1. What are the specific clinical goals of the recommended treatment? \_\_\_\_\_

2. What measurable objective(s) is the treatment expected to accomplish? (Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Reduction of Pain                              | <input type="checkbox"/> Decreased Use of Opioid Medication |
| <input type="checkbox"/> Self-Management of Pain                        | <input type="checkbox"/> Increased Independence with ADLs   |
| <input type="checkbox"/> Return to Work                                 | <input type="checkbox"/> Increased Function                 |
| <input type="checkbox"/> Other benefits of recommended treatment: _____ |   |

3. What is the recommended length of treatment?

Number of weeks: \_\_\_\_\_

Number of visits per week: \_\_\_\_\_

Intervals at which progress will be measured: \_\_\_\_\_

4. What is the projected outcome upon completion of the recommended treatment? \_\_\_\_\_

5. Please provide any other relevant information supporting the treatment recommendation: \_\_\_\_\_

Provider Signature \_\_\_\_\_

Printed Name \_\_\_\_\_ Date \_\_\_\_\_