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)

☐ Reduction of Pain

☐ Decreased Use of Opioid Medication

☐ Self-Management of Pain

☐ Increased Independence with ADLs

☐ Return to Work

☐ Increased Function

☐ 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**_____