INITIAL OT PATIENT SUBJECTIVE FORM

(Hand, Wrist, Elbow, Upper Extremity)

Name:_____Date:_____Age:_____
Dominant Hand: R L Sport/Activity:_____
Occupation:_____ Physical Demands:_____
Living Situation: Live Alone or with Spouse/Significant Other/Child/Children/Unrelated
History: Involved side: R L Both Shoulder Elbow Hand Wrist Fingers Thumb
Date of Onset/Injury/Surgery:_____
How did your problem occur:_____
Previous problems with arm or hand:_____
What is your chief complaint now:_____
Medical information
Physician:_____Diagnosis:_____
Medical tests(circle): MRI x-rays CT Scan Bone scan EMG Other:_____
Surgery: Y N What type:_____
Did you use : sling cast splint other:_____
Previous therapy : Y N When:_____
Other medical problems(circle): hypertension, diabetes, arthritis, cancer, pacemaker,allergies,
stroke,pregnancy,other_____
Do you consume any type of tobacco? Yes or No
Tobacco use is harmful to your health and we strongly urge that you discontinue use.
Pain rating: Indicate your average level of pain by circling the number on the scale:
0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10
mild moderate extreme agony
worst/highest pain level____best/lowest pain level____
Is pain: constant_____intermittent_____throbbing_____burning_____stabbing_____aching_____
Where is the pain located:_____
Activities that increase pain:_____
Activities that decrease pain:-_____
Other symptoms(circle): neck pain shoulder pain elbow pain wrist or finger locking
swelling deformity weakness radiating pain numbness/tingling skin temp/color change
Function: Indicate with the following numbers the degree of difficulty for each activity:
0=unable 1=great difficulty 2=moderate difficulty 3=minimal difficulty 4=no difficulty

____type/use keyboard	____drive car	____open/close buttons
____lean on hand	____pull up zipper	____place hand in pocket
____tie shoes	____receive change	____brush teeth
____housework	____lift cup/mug	____yardwork
____lift carton	____usual work	____writing

What goals do you hope to accomplish in Occupational Therapy_____
At the present time, would you say your health is excellent, very good, good, fair, or poor?
What activity/hobby/sport would you like to resume_____
When is your next doctor's appointment:_____
Patient signature:_____ **TURN PAGE OVER**

Reviewed by therapist:_____#_____Date:_____

Please provide a list of all your medications including prescription, over the counter, vitamins, and supplements, with dosage, frequency, and how administered (oral, injected, etc).

Medication	Dosage	Frequency	How Administered

CONSENT FOR CARE AND TREATMENT

I, the undersigned, having legal authority to do so, do hereby agree and give consent for Towson Sports Medicine to furnish medical care and treatment as considered necessary and proper in diagnosing or treating my/his/her physical and/or mental condition.

HIPAA

I, the undersigned, have been made aware of my rights as a patient under the "Health and Information Portability and Accountability Act" as posted in the office. I further understand that I may request a printed copy of these rights at any time.

MISSED APPOINTMENTS

Towson Sports Medicine requires that you give us **24 hours** notice of cancellations. If 24 hour advanced notice is not given, you may receive a **$25.00** missed appointment fee. Please contact **410-337-8847** to cancel appointments. This policy does not apply in situations of extreme weather. We also ask that you bring your appointment slip to each appointment.

Thank You!

I have read and understand the statements noted above.

Patient/Guardian/Responsible Party_____ Date_____

Please Print Your Name_____ Date_____

Towson Sports Medicine Representative_____ Date_____

Notice of Exclusions from Medicare Benefits
NEMB

Notice: As part of the American Taxpayer Relief Act of 2012 Medicare Beneficiaries currently have a "soft cap" cap of $1,940 and a "hard cap" of $3,700 for Physical and Speech Therapies combined and a separate $1,940 for Occupational Therapy **per calendar year.** This means at $1,940 we must provide written justification for continued therapy and at $3,700 you will have to stop treatment until Medicare approval is received. This is only justified in **extreme** cases.

The purpose of this form is to inform you of this in advance and that these monies are based on what Medicare pays (allowable amount), not on what Towson Sports Medicine charges. We will track your charges and inform you when you are nearing these limits.

If you have received therapy (PT, OT, or Speech) at any other outpatient location for any reason in the same calendar year, those visits are included. Failure to tell us about previous outpatient PT, OT, or Speech Therapy visits may cause you to exceed this cap and be personally liable for charges incurred beyond the $1940 amount.

Though you may elect to continue to receive care at our facilities, you may become personally liable for charges incurred after an allowable amount of $1940 if **you do not qualify. Please ask your therapist if you do not fully understand this**.

If you have a secondary or supplemental plan, they may **or may not** pay for additional fees once Medicare monies have been exhausted if you do not qualify for an exception. **Please check with your plan to determine their individual policies**. We will make every effort to check as well prior to your first visit. It should be noted that all deductibles will continue to apply.

It will be our policy to keep track for you those allowable charges incurred at our center so you can make informed decisions.

I **have** received outpatient rehabilitation services since January 1, 2015 _____ (initial)

(Please circle which therapies you have received OT PT Speech)

I **have not** received outpatient rehabilitation services since January 1, 2015_____ (initial)

By signing this form you are acknowledging that you have been informed of this Federal Policy and desire to receive rehab services at TSM.

Patient Name: _____*Date:*_____

*Patient Signature:*_____*Date:* _____

Towson Sports Medicine Fall Risk Screening

Medicare has requested that we ask all of our patients the following questions. Please answer all of the questions.

Thank You

1. **Have you fallen in the past year? Yes No**
2. **How many times have you fallen in the past year? _____**
3. **Please describe any injuries you have sustained from a fall**

   _____

   _____

   _____

   _____

4. **Please describe the circumstances of your last fall**

   _____

   _____

   _____

   _____

Date:_____ Initial:_____

_____

Date:_____ Initial:_____

_____

Date:_____ Initial:_____

Medicare has implemented quality measures requiring that we request certain information from our patients. Please answer questions to the best of your ability.

Geriatric Depression Scale (Short Form)

**Have you been diagnosed with depression or bipolar disorder? If yes, you do not need to complete this screen.

Patient's Name:_____ Date:_____

Instructions: Choose the best answer for how you felt over the past week.

No.	Question	Answer	Score
1	Are you basically satisfied with your life?	Yes/No	
2	Have you dropped many of your activities and interests?	Yes/No	
3	Do you feel your life is empty?	Yes/No	
4	Do you often get bored?	Yes/No	
5	Are you in good spirits most of the time?	Yes/No	
6	Are you afraid that something bad is going to happen to you?	Yes/No	
7	Do you feel happy most of the time?	Yes/No	
8	Do you often feel helpless?	Yes/No	
9	Do you prefer to stay at home, rather than going out and doing new things?	Yes/No	
10	Do you feel that you have more problems with memory than most?	Yes/No	
11	Do you think it is wonderful to be alive?	Yes/No	
12	Do you feel pretty worthless the way you are now?	Yes/No	
13	Do you feel full of energy?	Yes/No	
14	Do you feel that your situation is hopeless?	Yes/No	
15	Do you think that most people are better off than you are?	Yes/No	
		Total	

Scoring:

Assign one point for each of these answers:

1. No	4. Yes	7. No	10. Yes	13. No
2. Yes	5. No	8. Yes	11. No	14. Yes
3. Yes	6. Yes	9. Yes	12. Yes	15. Yes

A score of 0 to 5 is normal. A score above 5 suggests depression

Source:

- Yeavage J.A., Brink T.L., Rose T.L et al. Development and evaluation of geriatric depression screening scale: a preliminary report. J. Psychiatr. Res. 1983; 17:37-49