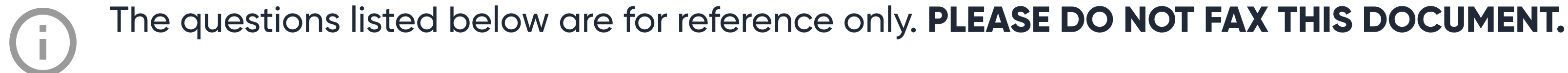
cohere HEALTH

Occupational Therapy (Outpatient Only)



The questions listed below are for reference only. **PLEASE DO NOT FAX THIS DOCUMENT.**

Patient Information

First name	Last name

Member ID	Date of birth (MM/DD/YYYY)

Special Note

A max of 4 visits may be eligible for auto approval on initial occupational therapy requests on this Single Service.

Question 1

Which side is symptomatic? (Required, fill in all that apply)

- ☐ Left
- ☐ Right
- ☐ Not applicable, symptoms are not localized

Question 2

Which of the following findings were documented at the most recent encounter? (Required, fill in all that apply)

- ☐ Elbow pain, weakness, or limitation of motion
- ☐ Hand pain, weakness, or limitation of motion
- ☐ Finger pain, weakness, or limitation of motion
- ☐ Wrist pain, weakness, or limitation of motion
- ☐ Neck pain, weakness, or limited motion
- ☐ Back pain, weakness, or limited motion
- ☐ Shoulder pain, weakness, or limited motion
- ☐ Hip pain, weakness, or limited motion
- ☐ Knee pain, weakness, or limited motion
- ☐ Foot / Ankle pain, weakness or limited motion
- ☐ Pelvic pain or incontinence
- ☐ Vertigo or Poor Balance
- ☐ Unspecified Arthritis
- ☐ Developmental delay
- ☐ None of the above

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