Required Clinical Information

Program		Required Medical Information
Radiology Program		Rule out/diagnosis
		Symptoms
		Physical Exam findings
		Treatment such as medications, physical therapy, surgery; chemotherapy
		Re-evaluation post treatment for some indications
		Recent relevant imaging
		Recent relevant laboratory work
		Pertinent medical history and family history
		For imaging exam requests for cancer, indicate if the exam is requested for initial staging or restaging following treatment or surveillance. Please provide the type and stage of cancer, date of diagnosis, type of treatment and date of treatment completion.
Cardiology Program		Current office notes
		Lipid panels
		Reports of current electrocardiograms (EKGs) signed by doctors
		Reports of previously performed left heart catheterizations, nuclear stress tests, routine exercise stress tests, echocardiograms and stress echocardiograms (as applicable) previous cardiac imaging studies (CT, MR, PET)
Sleep Program		Reason and type of study Requested
		Complaints and symptoms, length of time experiencing symptoms
		If there was a prior sleep study, date and what type of study
		List of current medications
		Co-morbid conditions with recent supporting office notes and length of time with conditions
		If repeat test, reason for the need to repeat
		Has the patient ever been on PAP therapy before, date
		Epworth Sleepiness Scale
		BMI
		STOP-BANG assessment

Required Clinical Information

Program		Required Medical Information
Radiation (Oncology) Therapy Program		Site of treatment and/or cancer type
		Reason for Treatment
		Technique to be used, and start date (should be the first day of treatment, not simulation). Will IGRT be needed?
		Staging of the cancer, if applicable
		Recent imaging if applicable
		Number of phases of treatment if more than one, and number of fractions
		Radiation Oncologists consultation note
		Pertinent clinical information to substantiate medical necessity for requested treatment plan
Musculoskeletal Program Spine Surgery		Date of first office visit related to this condition and/or after symptoms began
		Signs/Symptoms
		Last office visit including re-evaluation
		Physical exam findings
		Previous medical history
		Duration and type of physician-directed treatment
		Outcomes of prior surgical/non-surgical physician-directed treatment and prior surgical/non-surgical interventions
		Results of relevant prior imaging related to the request including the radiologists report of advanced diagnostic imaging studies
Musculoskeletal Program Joint Surgery		Date of most recent physical exam along with physical exam findings and patient complaints
		Medical history/duration of complaints
		Dates/duration/response to conservative treatment such as medication and various therapies (please specify)
		Other pertinent medical history/comorbidities
		Prior imaging films/reports with date of service (MRI, CT, X-ray or bone scan)
		Severity of pain and details of functional disabilities interfering with activities of daily living
		Physician's treatment plan

Required Clinical Information

Program		Required Medical Information
Musculoskeletal Program for Pain Management		CPT codes and specific levels of injection and/or specific muscle groups to be injected. Specific prior injection history with dates/level/side/response to injection, especially if it is an injection into the same vertebral region (e.g. cervical, thoracic or lumbar spine)
		Total number of injections/procedures in the past 12 months for the diagnoses (to include all prior doctors)
		Date of most recent physical exam along with physical exam findings and patient complaints
		Medical history/duration of complaints
		Other pertinent medical history/comorbidities
		Name of injectant
		Type or method of radiofrequency ablation and/or percutaneous decompression
		Dates/duration/response to conservative treatment such as medication and various therapies (please specify)
		Type or method of radiofrequency ablation
		Specify imaging guidance type
		Date of MRI and other imaging with findings
		Proposed date of service for current request
		Any anesthesia requirements
Musculoskeletal Program Specialty Therapy (PT/OT)		*Feel free to utilize the appropriate Clinical Worksheet/Guide as a tool/resource.*
		Primary and Secondary Diagnosis/ICD10
		Co-morbidities/Complexities that will impact the therapy plan of care
		Standardized test scores (a minimum of annually for pediatric neurodevelopmental conditions
		Functional Outcome Measures/Patient Reported Outcome Scores
		Surgery – Date and type
		New condition not previously treated or previous condition
		Date of current findings
		Average level of pain (Rate 1 - 10)
		List of activities the patient isn't able to perform within the last week (Rate level of difficulty 1 - 10)
		Provide current pain medication
		How many new re-occurrences has the patient experienced in last 12 months?
		Patients response to care
		Reasons for patient not responding to care
		Patients status to Provider prescribed pain medication