Conservative Treatment History Form (Advanced Imaging)

There is significant value in conservative treatment. It is also important to document and for any provider to document recent efforts before establishing further tests and or treatment.

Please type or print clearly. Upload this document via the RadMD Upload Feature. Instructions for how to submit clinical information may be found on the RadMD.com homepage under References. Processing may be delayed if information submitted is illegible or incomplete.

Today's Date:	Patient Name:
Tracking Number:	Date of Birth:
Clinical Questions?	
Has the patient had these symptoms for six months or more?	☐ **YES** ☐ **NO**
If no to the above, how long has the patient had these symptoms?	
Has the patient attempted any **inactive** components of conservative care? (Rest, activity modification, pain meds, injections, steroids or brace etc.)	☐ **YES** ☐ **NO**
Is this request related to concern for **infection** or abscess based on Labs, fever, physical exam findings or prior imaging such as Xray or US?	☐ **YES** ☐ **NO**
Does the Patient have known or suspected **malignancy** or mass?	☐ **YES** ☐ **NO**
Is this request related to **Pre-Operative** planning with planned surgery?	☐ **YES** ☐ **NO**
Does the patient have a diagnosis of **Multiple Sclerosis** or Does the patient have suspected demyelinating disease based on signs/symptoms?	☐ **YES** ☐ **NO**
Does the patient have documented recent **trauma** with known or suspected fracture?	☐ **YES** ☐ **NO**
Have you tried any of the following active treatments?	
Chiropractic care?	☐ **YES** ☐ **NO**
Physical Therapy?	☐ **YES** ☐ **NO**
Physician supervised home exercises for this problem?	☐ **YES** ☐ **NO**
For which spinal area has therapy been completed?	☐ **C-SPINE** ☐ **T-SPINE** ☐ **L-SPINE**
For Which Joint has therapy been completed?	☐ **SHOULDER** ☐ **KNEE** ☐ **HIP** ☐ **ELBOW** ☐ **WRIST** ☐ **ANKLE** ☐ **FOOT** ☐ **HAND** ☐ **OTHER**

If yes to *chiropractic* care, please complete this section.

Chiropractic treatment start date? _____ Date of last session? _____

How many sessions? _____ How does patient feel after doing the therapy? ☐ **BETTER** ☐ **SAME** ☐ **WORSE**

If yes to *physical therapy*, please complete this section.

Physical Therapy start date? _____ Date of last session? _____

What type(s) of exercises/modalities? _____

How many sessions? _____ How does the patient feel after doing the therapy? ☐ **BETTER** ☐ **SAME** ☐ **WORSE**

If yes to *physician supervised home exercises*, please complete this section.

Name of supervising Physician? _____

What type of exercises? _____

Who gave you the exercise plan? _____

Home exercise program start date? _____ Date of last session? _____

How many times per week does the patient perform the physician recommended exercise? _____

What was the date of in office physician reassessment when failure was determined? _____

How does the patient feel after doing the supervised home therapy? ☐ **BETTER** ☐ **SAME** ☐ **WORSE**

By making this submission, I attest, either as the ordering provider or as authorized by the ordering provider, that all statements made herein are true and verified by specific documentation in the medical record of the applicable patient, and I/the ordering provider understand(s) that misrepresentations made in this submission may be investigated for fraud, and/or abuse.

I attest that standard initial clinical workup (physical examination, laboratory testing, and review of prior abnormal imaging reports) has been completed and treatment has failed to improve the patient's clinical condition.

☐ I ATTEST ☐ I DO NOT ATTEST

_____	_____
Patient Name	Provider Signature or Individual Completing Form on Behalf of Provider

** Effective 1/20/2023, Magellan Hawai'i is now a subsidiary of Evolent Health. Evolent Health and its affiliates and subsidiaries collectively referred to as "Evolent."*