**NOBLE NARRATIVE CREATION CHECKLIST**

**Please complete this checklist and attach it to the top your submission package**

**Scan and email file to: (Print Neatly)**

**noblenarratives@gmail.com**

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M / F Age\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_DOA:\_\_\_\_\_\_\_\_\_\_\_\_**

**Circle Y if enclosed or N if not:**

**Y N Patient's initial written intake/history form**

**Y N Your Initial Evaluation: Dated \_\_\_\_\_\_\_\_\_\_\_\_ EHR FORMAT only NO Checklists**

**Y N Your Final/Current evaluation: Dated \_\_\_\_\_\_\_\_\_\_\_\_** **EHR FORMAT only NO Checklists**

**Y N Attorney's Name and address so we can address the report for you**

**Y N Diagnostic reports (MRI, CT scan, X-ray digitization, EMG/NCV, etc.)**

**Y N All treating doctors/therapists’ reports (orthopedist, neurologist, physiatrist, etc.)**

**Y N Patient's own Functional Loss in their own words NO Checklists-FINAL/CURRENT ONLY**

**Y N Executed (signed) HIPAA Chain of Trust Agreement (ONLY WITH FIRST REPORT FOR YOU)**

***Do NOT send daily SOAP notes, Re-evaluations, Oswestry or similar forms***

**Dr. (name on report) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City and State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dr. Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email to send report: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Total Number of Chiropractic treatments: \_\_\_\_\_\_\_Dates of all Chiropractic evaluations and re-evaluations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Total Number of Physical Therapy treatments: \_\_\_\_\_ *DONE BY A LICENSED PT (not Chiro) Regions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Gap in Initial Care? Y N (Covid-19, went to another doc, self-medicated, thought it would go away, etc.)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Gap in Care (other) Y N (Covid-19, went on vacation, death in family, done prior to final evaluation)**

**Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **If you can’t scan then fax to: (855-292-0803)-Clean your fax/scanner weekly!!**

***Let me know what Credentials You Have received and would like on each of your reports (send (via e-mail))***

***ANYTHING ELSE I NEED TO KNOW ATTACH A SEPARATE PAGE AFTER THIS ONE PLEASE***