NARRATIVE CREATION CHECKLIST

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

Scan and email file to:

dr.michael@academyofchiropractic.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 Initial evaluation: Dated _____ EHR FORMAT only NO Checklists
Y N Final 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 (personal – social – work statements-FINAL ONLY
Y N Executed (signed) HIPAA Chain of Trust Agreement (ONLY ONCE)

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

Print clearly

Dr.'s (name on report) Name: _____

City and State: _____

Dr. Cell #: _____ Email to send report: _____

Total Number of Chiropractic treatments:_____Dates of all Chiropractic evaluations and re-evaluations including final:_____

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

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

_____

Gap in Care (other) Y N Reason (went on vacation, death in family, done prior to final evaluation, etc.)

_____

Anything else we should know about this case?

_____

TOTAL NUMBER OF PAGES _____ If you can't scan fax to: (888-977-1893)

12/22/19