

American Specialty Health Networks (ASH Networks)
P. O. Box 509001, San Diego, CA 92150-9001
FAX: 877/248-2746

PROGRESS EVALUATION
Kaiser Permanente Acupuncture Referral Program
For questions, please call ASH Networks at 888/226-8879

Patient Name _____ Date _____

Kaiser Permanente Medical Record Number _____

Referring Kaiser Permanente Physician _____ Phone # _____

FAX Number _____

Treating Acupuncturist _____ Phone # _____ Fax # _____

Diagnosis Name _____ Referring ICD 9 Code _____

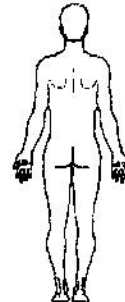
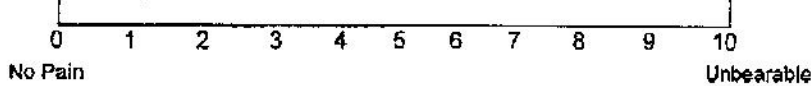
Patient: Please complete the following portion of this form.

Current Conditions/Complaints

Rate your overall progress since starting care

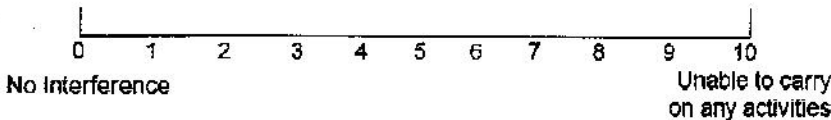
- | | | | | | | |
|----------|---------|-----------------|-------------|------|------|-----------|
| 1. _____ | _____ % | (or circle one) | no progress | fair | good | excellent |
| 2. _____ | _____ % | (or circle one) | no progress | fair | good | excellent |

i. Circle your pain level



- Has your pain improved? Yes No
 Is the relief only temporary? Yes No
 For how long? _____ hrs/days

ii. In the past week, how much has your pain interfered with your daily activities (e.g. work, social activities, or household chores)?



Patient Signature: _____ Date: _____

Treating Acupuncturist: Please Complete the Following Summary.

Treating Acupuncturist Diagnosis Name: _____ ICD9 Code: _____

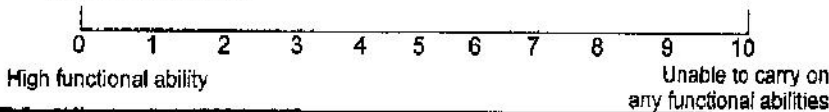
The current Acupuncture Treatment Plan Includes:

- | | |
|--|--|
| <input type="checkbox"/> Acupuncture treatment | <input type="checkbox"/> TuiNa/Acupressure/Massage therapy |
| <input type="checkbox"/> Nutritional supplements/herbs | <input type="checkbox"/> Rehab Exercise |
| <input type="checkbox"/> Cupping | <input type="checkbox"/> Home Care Advice |
| <input type="checkbox"/> Moxibustion | <input type="checkbox"/> Other _____ |

Based on Your Clinical Expertise, the Previous Acupuncture Treatments Were Considered:

- Successful Some improvement Unsuccessful Reached maximum therapeutic benefit Other _____

iii. How would you rate the quality of your patient's daily function or functional abilities



What Would You Like to Recommend to the patient's Referring Physician? (Check all that apply)

- Continued acupuncture treatment Discharge the patient from acupuncture care Refer to other practitioner
 Return patient to referring physician for evaluation Call me to discuss any future care Other: _____

Comments: _____

Acupuncturist Signature: _____ Date: _____