

RateFast Express Reporting Form

(Please use ONE form per body part)

Cervical Spine



Date of Submission:	Patient Name:	
Practice:	DOB:	DOI:
Provider Name:	Provider Name:	
Insurance:	Claim #:	

Step 1. Body part: Cervical Spine (only use this form for Cervical spine injuries. Get forms for other body parts at www.rate-fast.com)

Step 2. Indicate severity of pain/symptoms based on impact Activities of Daily Living (ADLs). Check one below:

Indicate symptoms severity below. Check one:

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> None
No pain/symptoms or impact to ADLs. | <input type="checkbox"/> Mild
Mildly aggravated while performing ADLs | <input type="checkbox"/> Moderate
Some difficulty managing ADLs | <input type="checkbox"/> Severe
Can only perform ADLs with substantial modifications | <input type="checkbox"/> Very severe
Must get help from others for many ADLs |
|---|---|---|--|--|

Indicate General Patient History

Past Medical History	Social History	Substance Use	Social Activity
<input type="checkbox"/> Contributory <input type="checkbox"/> Non Contributory	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Family <input type="checkbox"/> Sports <input type="checkbox"/> Outdoors <input type="checkbox"/> Other

Step 3. Check One in Each Row/Exam Findings:

- | | | | | |
|---------------------|-------------------------------------|-------------------------------------|--|--------------------------------------|
| Inspection | <input type="checkbox"/> No Scars | <input type="checkbox"/> Scars | | |
| Palpation | <input type="checkbox"/> Non-Tender | <input type="checkbox"/> Guarding | | |
| Motion | <input type="checkbox"/> Normal | <input type="checkbox"/> Minor Loss | <input type="checkbox"/> Spasm | |
| Motor Loss | <input type="checkbox"/> None | <input type="checkbox"/> Minor | <input type="checkbox"/> Moderate Loss | <input type="checkbox"/> Severe Loss |
| Sensory Loss | <input type="checkbox"/> None | <input type="checkbox"/> Tingling | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Reflexes | <input type="checkbox"/> Symmetric | <input type="checkbox"/> Asymmetric | <input type="checkbox"/> Decreased | <input type="checkbox"/> Absent |

Step 4. Spine conditions. Check the box for each relevant level and condition.

	Arthritis	Herniated disc	Spondylolisthesis (Instability)	Compression fracture	Transverse / posterior element fracture	Decompression surgery	Injections / LESI	Fusion surgery
C2-3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C3-4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C4-5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C5-6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C6-7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C7-T1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How many injections? How many surgeries?

If arthritis is present, what is the severity? Mild Moderate Severe

Severity of compression fracture? N/A Mild Moderate Severe

Do the arms currently have pain/symptoms?

Right arm: None Above the elbow Below the elbow

Left arm: None Above the elbow Below the elbow

Step 5. Future Care. Indicate any future treatments that may be necessary.

<input type="checkbox"/> Medication	<input type="checkbox"/> Therapy	<input type="checkbox"/> Specialty Care	<input type="checkbox"/> Other	<input type="text"/>
<input type="checkbox"/> Diagnostic tests	<input type="checkbox"/> Injections			

Step 6. Securely email or fax this document with the Doctor's First Report, last "MMI" PR-2 report, surgical/procedure/consult notes, and imaging and diagnostic reports to RateFast at: **Email:** express@rate-fast.com **Fax:** (707) 921-7924