RateFast Express Reporting Form

Provider Name:	Practice Name:	Date of Submission:
Practice Address/Location:		
Patient Name:		DOB:
Insurance:	Claim #:	Date of Injury:

Choose body part(s) for rating:	Rate Pain/Symptoms Level on 0 to 10 Scale		For selected body parts, provide the pain level for each side that is affected by the injury/condition.
Spine	**Pain/Symptoms Level**		**Comments**
☐ Cervical	___ / 10		
☐ Thoracic	___ / 10		
☐ Lumbar	___ / 10		
Upper Extremity	**Pain/Symptoms Level**		**Comments**
	Right Side	**Left Side**	
☐ Entire Arm	___ / 10	___ / 10	
☐ Entire Hand	___ / 10	___ / 10	
☐ Shoulder	___ / 10	___ / 10	
☐ Elbow	___ / 10	___ / 10	
☐ Wrist	___ / 10	___ / 10	
☐ Thumb	___ / 10	___ / 10	
☐ Index Finger	___ / 10	___ / 10	
☐ Middle Finger	___ / 10	___ / 10	
☐ Ring Finger	___ / 10	___ / 10	
☐ Little Finger	___ / 10	___ / 10	
Lower Extremity	**Pain/Symptoms Level**		**Comments**
	Right Side	**Right Side**	
☐ Entire Leg	___ / 10	___ / 10	
☐ Hip	___ / 10	___ / 10	
☐ Knee	___ / 10	___ / 10	
☐ Ankle	___ / 10	___ / 10	
☐ Great Toe	___ / 10	___ / 10	
☐ Lesser Toe(s)	___ / 10	___ / 10	
Other	**Pain/Symptoms Level**		**Comments**
	Right Side	**Right Side**	
☐ Inguinal Hernia	___ / 10	___ / 10	
☐ Umbilical Hernia	___ / 10	___ / 10	
☐ Vision	___ / 10	___ / 10	
☐ Hearing	___ / 10	___ / 10	
☐ Skin	___ / 10	___ / 10	
☐ Psychiatric	___ / 10		
☐ Pulmonary/COVID	___ / 10		
☐ Other:	___ / 10		

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