

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	
<input type="checkbox"/> Cervical	___ / 10			
<input type="checkbox"/> Thoracic	___ / 10			
<input type="checkbox"/> Lumbar	___ / 10			
Upper Extremity	Pain/Symptoms Level		Comments	
	Right Side	Left Side		
<input type="checkbox"/> Entire Arm	___ / 10	___ / 10		
<input type="checkbox"/> Entire Hand	___ / 10	___ / 10		
<input type="checkbox"/> Shoulder	___ / 10	___ / 10		
<input type="checkbox"/> Elbow	___ / 10	___ / 10		
<input type="checkbox"/> Wrist	___ / 10	___ / 10		
<input type="checkbox"/> Thumb	___ / 10	___ / 10		
<input type="checkbox"/> Index Finger	___ / 10	___ / 10		
<input type="checkbox"/> Middle Finger	___ / 10	___ / 10		
<input type="checkbox"/> Ring Finger	___ / 10	___ / 10		
<input type="checkbox"/> Little Finger	___ / 10	___ / 10		
Lower Extremity	Pain/Symptoms Level		Comments	
	Right Side	Right Side		
<input type="checkbox"/> Entire Leg	___ / 10	___ / 10		
<input type="checkbox"/> Hip	___ / 10	___ / 10		
<input type="checkbox"/> Knee	___ / 10	___ / 10		
<input type="checkbox"/> Ankle	___ / 10	___ / 10		
<input type="checkbox"/> Great Toe	___ / 10	___ / 10		
<input type="checkbox"/> Lesser Toe(s)	___ / 10	___ / 10		
Other	Pain/Symptoms Level		Comments	
	Right Side	Right Side		
<input type="checkbox"/> Inguinal Hernia	___ / 10	___ / 10		
<input type="checkbox"/> Umbilical Hernia	___ / 10	___ / 10		
<input type="checkbox"/> Vision	___ / 10	___ / 10		
<input type="checkbox"/> Hearing	___ / 10	___ / 10		
<input type="checkbox"/> Skin	___ / 10	___ / 10		
<input type="checkbox"/> Psychiatric	___ / 10			
<input type="checkbox"/> Pulmonary/COVID	___ / 10			
<input type="checkbox"/> 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