

RateFast Express Reporting Form

(Please use ONE form per body part)



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

Step 1. One body part per sheet. Please check ONE body part below:

SPINE:	UPPER EXTREMITIES:	R	L	LOWER EXTREMITIES:	R	L	VISION HEARING:	R	L
<input type="checkbox"/> Cervical	Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Hip	<input type="checkbox"/>	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Thoracic	Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Knee	<input type="checkbox"/>	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumbar	Wrist	<input type="checkbox"/>	<input type="checkbox"/>	Ankle	<input type="checkbox"/>	<input type="checkbox"/>			
	Thumb	<input type="checkbox"/>	<input type="checkbox"/>	Great Toe	<input type="checkbox"/>	<input type="checkbox"/>			
Skin:	Index	<input type="checkbox"/>	<input type="checkbox"/>	Lesser Toe(s)	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Skin	Middle	<input type="checkbox"/>	<input type="checkbox"/>	PULMONARY:			HERNIA:		
	Ring	<input type="checkbox"/>	<input type="checkbox"/>	Lungs (general)	<input type="checkbox"/>		Inguinal Right Side	<input type="checkbox"/>	
	Little	<input type="checkbox"/>	<input type="checkbox"/>	Lungs (Covid-19)	<input type="checkbox"/>		Inguinal Left Side	<input type="checkbox"/>	
							Umbilical Hernia	<input type="checkbox"/>	

PSYCHIATRIC: Describe condition and indicate severity of condition below:

Describe (Psychiatric cases only):				
<input type="checkbox"/> None No anxiety, depression, insomnia, social impact or other symptoms.	<input type="checkbox"/> Mild Anticipated anxiety, mild depression, insomnia, slight social difficulty.	<input type="checkbox"/> Moderate Transient anxiety, insomnia, flat affect, obsessive behavior, social difficulty.	<input type="checkbox"/> Severe Occasional panic attack, severe insomnia, manic, obsessive behavior, difficulty with family and work, no friends, etc.	<input type="checkbox"/> Very severe Non-functional, delusions, violent behavior, family neglect, no home, etc.

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
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Indicate Pain Level and Pain Frequency

Pain Level: On a scale from 0 to 10, with 10 being highest. _____ out of 10

Pain Frequency 25% of day 50% of day 75% of day 100% of day

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

Inspection	<input type="checkbox"/> No Scars	<input type="checkbox"/> Scars		
Chest Auscultation	<input type="checkbox"/> Normal	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Rhochi	<input type="checkbox"/> Crackles
Palpation	<input type="checkbox"/> Non-Tender	<input type="checkbox"/> Guarding		
Motion	<input type="checkbox"/> Normal	<input type="checkbox"/> Minor Loss	<input type="checkbox"/> Moderate Loss	<input type="checkbox"/> Severe Loss
Motor Loss	<input type="checkbox"/> None	<input type="checkbox"/> Minor	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Sensory Loss	<input type="checkbox"/> None	<input type="checkbox"/> Tingling	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent

Step 4. Check all diagnostic tests that have been completed:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
<input type="checkbox"/> Soft Tissue	<input type="checkbox"/> Normal	<input type="checkbox"/> Ligament Tear	<input type="checkbox"/> Herniated Disk	<input type="checkbox"/> Degenerative
<input type="checkbox"/> Structural	<input type="checkbox"/> Normal	<input type="checkbox"/> Instability	<input type="checkbox"/> Fracture	<input type="checkbox"/> Fusion
<input type="checkbox"/> Nerve Studies	<input type="checkbox"/> Normal	<input type="checkbox"/> Sensory Loss	<input type="checkbox"/> Motor Loss	<input type="checkbox"/> Motor+Sensory Loss
<input type="checkbox"/> Pulmonary Function Test	<input type="checkbox"/> Normal	<input type="checkbox"/> > 59% predicted	<input type="checkbox"/> > 51 to 59% predicted	<input type="checkbox"/> < 51% predicted

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

Diagnostic tests Injections Specialty Care Other _____

Step 6. Apportionment. Select all that apply and provide percentages.

Imaging degenerative changes _____% Pre-existing condition _____% Other _____%

Total Non-industrial apportionment _____%