Horizon

Horizon Blue Cross Blue Shield of New Jersey

PT/OT Initial Evaluation Report

You may complete the required fields below online and then save or print a copy for submission. To save a completed copy to your computer, choose File > Save As to rename the file and save the form with your information to your computer.

Product ***(check one):*** ☐ Horizon HMO ☐ NJ PLUS ☐ Horizon POS ☐ Horizon Direct Access ☐ Medicare Advantage

Today's Date: _____ / _____ / _____
MM DD YYYY

Patient Name: _____ _____ _____
Last First MI

Patient ID #: _____ Date of Birth: _____ / _____ / _____ Age: _____
MM DD YYYY

Date of Injury: _____ / _____ / _____ Date of Surgery: _____ / _____ / _____
MM DD YYYY MM DD YYYY

ICD-9 Code(s): _____ Diagnosis: _____

Referring Physician: _____ Referring Physician ID #: _____

Therapy Office (Site/Location): _____ Discipline: ☐ PT ☐ OT

Address: _____ City: _____ State: _____ ZIP: _____

OBJECTIVE FINDINGS Involved Region: ☐ Left ☐ Right ☐ N/A

Strength (0-5)		**Range of Motion**		
Motion	Grade	Motion	PROM	AROM

How/Where Injury Occurred: _____ **Work Related?** ☐ Yes ☐ No

Pertinent History: _____

_____

Pain: Pain Scale: 1 to 10 (10 being the highest) _____

Nature: ☐ constant ☐ intermittent ☐ localized radiating

Functional Deficits/Additional Information: _____

_____

_____

Specific Treatment Plan: _____

_____

_____

Treatment Goals: _____

_____

_____

Projected Frequency/Duration of Treatment: _____ **Visits Requested:** _____

Therapist Signature: _____ **License #:** _____

Printed Therapist Name: _____ _____ _____
Last First MI

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