KAISER PERMANENTE®

# CLINICAL INFORMATION REQUEST FORM

**Instructions:**

- Complete one clinical request form per patient; all fields must be completed.

| | | |
|---|---|---|
| **Date:** | | |
| **Organization:** | | |
| **Organization Address:** | | |
| **Organization City:** | **Organization State:** | **Organization Zip Code:** |
| | | |
| **Patient Name:** | **Patient Date of Birth:** | |
| **Servicing Practitioner Name:** | **Servicing Practitioner License:** | |
| **Servicing Practitioner NPI:** | | |
| **Servicing Practitioner Phone Number:** | | |

| **Treatment Plan & Goals** | |
|---|---|
| **Primary Diagnosis:** | **ICD-10 Code:** |
| **Outline or Describe Associated Symptoms being treated:** | |
| **Treatment Goal (Specific, Measurable):** | |
| **How are treatment goals being measured (standardized or evidenced based clinical scores or tools, etc.)?** | |
| **Outline Progress towards Goal (including any changes in symptoms and response to treatment as measured by the method outlined above, including baseline and current clinical scores):** | |

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**Current Status (Mark One):**

☐ Resolved ☐ Significant Progress ☐ Moderate Progress ☐ Little Progress ☐ No Progress ☐ Declining

**If patient is not progressing toward meeting therapeutic goals:**

1. **Describe the reason for lack of progress:**

2. **What changes in treatment (Treatment Modality, Specific, Measurable Goals, and Interventions) are being made to help patient progress in treatment?:**