NAME: _____

CLINICAL INFORMATION REQUIRED FOR AUTHORIZATION

SYMPTOMS:
What symptoms are you experiencing and for how long?

TRAUMA:
Are your symptoms a result of trauma and if yes, when?

MEDICATION (S):
What kind of medication(s) do you take and when did you start?

TREATMENT/THERAPY:

Have you had treatment and/or therapy and if yes, what kind and start date?

SURGERIES:
What body part and when?

BLOOD WORK:
When did you have blood work done last?

LAST OFFICE VISIT (S):
When were your last 2 office visits?

IMAGING:
Have you had any other imaging recently and if yes, what modality, body part and where?