

INSTRUCTIONS FOR DATA SCANNING FORMS COMPLETION  
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OBJECTIVE

These medical and history evaluation forms are intended to efficiently organize your history and physical exam according to the guidelines and avoid dictation whenever possible. The evaluation form should include your entire history, physical, and treatment plan. Information recorded anywhere else will not be included in the study. Please complete the scanning forms before you dictate. If there is need to dictate, you should cover areas you cannot fully complete on the evaluation form.

The data scanning form provides statistics on history and physical findings, treatment ordered, and outcome of case. Using this information we will be able to determine whether compliance with the guidelines in various aspects has any relationship to the patient's final return-to-work status and length of disability. The information will support quality assurance and guideline revision.

GENERAL INSTRUCTIONS

1. Patient Identifying Information. Please stamp pages one and three of the forms in the area provided (top right corner of the page). It is important that you not mark over the black box in the upper corner, as it this used by the scanner to recognize the specific forms. For our purposes, we only need to be able to identify the patient's medical record number so please be sure that this is legible.
2. Dates. Any dates with blocks around them will be recorded in the data scanner. It is important that you write the numbers as clearly as possible. If we cannot read the dates or if you do not fill in dates, we will have to call you to confirm this information.
3. Circle Options. For most areas, you will need to mark or fill in the small circle appropriate for the question. Any writing instrument can be used. Be careful not to mark in circles that you did not mean to include, or the data scanner will record these also. Most history sections do not include a positive or negative response. Therefore, if you do not fill in the circle, it is assumed that you have asked the question on the form and that the response is negative. If you wish to comment further on negative responses, do not fill in the circle. For bill coding purposes, we suggest that you comment on negative responses instead. If you make an error, put a large X over the circle and fill in the correct response.
4. Other Space. There are many areas with a blank line or spaces. These areas are for your convenience. The data scanner will not record the additional information. Some of the information may be used later in the study for qualitative research. You may write in any space on the form as long as the writing does not enter a circle or block.

## GENERAL FORM INFORMATION

**Pain level.** To record this, ask the patient to numerically represent the level of the pain they are experiencing. This must be a whole number. 10 = a level of pain which would cause you to consider suicide. 1 = a minimal level of pain that doesn't interfere with daily activities, e.g., mild headache.

**Quality of Pain.** Write in the type of pain, e.g., aching, sharp.

**Past Medical History -** Check all that apply.

Past LBP	history of low back pain
LB Surgery	low back pain surgery
HTN	hypertension
CAD	coronary artery disease
IDDM	insulin dependent diabetes mellitus
DM Non-ID	diabetes mellitus non-insulin dependent
PUD	peptic ulcer disease
UTI	urinary tract infection

Some circles on the form allow you to refer to your clinic chart or dictation. These areas are for your convenience and will not be included in the study.

**Allergies.** NKDA means no known drug allergies.

**Review of Systems.**

GI	gastrointestinal
CV	cardiovascular
Endo	endocrine
Neuro	neurologic including peripheral neuropathy, additional space is required for detailed commentary

**Risk Factors for Delayed Recovery.** Prior to this section, you have marked areas in which there was a finding only. Negatives were not recorded. In this section, you will need to note any question asked, and the response. If you do not mark the section, it will be assumed that you did not ask any questions in this area or obtain any information. If you asked a question and a risk factor was identified, you will mark "yes". If no problems were identified, mark "no".

- **Substance abuse** refers to any history or addictive drug or alcohol use, *past or present*.
- **Physical, emotional or sexual abuse** refers to any history of such abuse or any current abuse. The patient will need to be asked directly whether this has occurred.

- **Family situations** refer to marital problems; problems with children; taking care of a disabled, elderly or extremely ill family member; family history of disability or change in family role or family support.
- **Psychological history** refers to any history of treatment for depression, bipolar disorder, etc. In particular, you should record any history suggesting a prior DSM IV diagnosis not related to substance abuse or sexual abuse. History of counseling related to a divorce or a death in a family with no other accompanying pathology should be checked as no psychological factors and comment in the chart regarding what occurred.
- **Injury-related issues** refer to delayed presentation of chronic pain symptoms, unrealistic expectations of work capacity, patient feels injury is due to unsafe workplace, or unreasonable presentation of severity of symptoms given the nature of the problem.
- **Legal factors** include issues regarding level of income, level of education, and legal representation.
- **Employment problems** include such issues as dissatisfaction with the job, ability to get along with supervisors, conflicts with other workers, low challenge or low control in specific job positions. For this question, we definitely recommend that you write in the details when you have received a yes answer.

**Red Flag History.** Mark only those noted to be abnormal. For spinal infection, risk factors include signs of infection and history of IV drug use or immuno-compromised status.

**PE.** Record all parts of the exam you performed as normal or abnormal.

**SLR or Straight Leg Raising.** It is positive only if the patient experiences radicular symptoms distal to the knee with straight leg raise. A sitting straight leg raise should produce the same signs as a prone straight leg raising and can be used to check for consistency. A crossed straight leg raise occurs when a straight leg raise on one side causes radicular symptoms in the non-tested leg and is highly productive of sciatic nerve tension.

**Waddell's Signs** - 3/5 indicates non-organic exam.

*Simulation tests:*

- Axial loading
- Simulated trunk rotation

*Distraction:*

- Sitting vs. supine straight leg raising test
- Bending
- Limping

*Regional Disturbances:*

- Cogwheel or non-myotonic distributed weakness
- Non-anatomic sensory loss (stocking glove)

*Non-specific Tenderness:*

Superficial tenderness

Non-anatomic tenderness

*Overreaction:*

Excessive verbalization of pain

Excessive facial expression of pain

Collapsing episodes

Excessive sweating

**Investigations.** In some cases, the patient will have been seen in the emergency room or by another physician before your initial visit. In this case, mark any exams performed by the previous physicians under "performed previously." If you performed the exam and evaluated the results, be sure to record the results in the written section below investigations.

**Special Considerations in the Case.** In this area, you are allowed to write anything that you believe may make the case more difficult and which has not yet been addressed. For instance, the patient may have delayed seeking care for this problem.

**Diagnoses.** Please mark all diagnoses that apply both primary and secondary.

**Education Discussed.** In this area, it is important that you note what was specifically discussed with the patient. Under "natural history and expectations" this would include any discussion of the natural progression of a particular disease or treatment and what the patient's expectations should be for recovery. Aftercare instructions refer to when the patient should be seen again and what would constitute the need for an emergency visit. Body mechanics refer both to exercise and discussion of body mechanics at work and at home.

**Education Provided.** We are referring to any written information given to the patient. Included are exercise instructions, aftercare instructions, and any educational pamphlets discussing the pathophysiology of the patient's condition.

**Activity Modification.** If bed rest is ordered for the patient, record the number of days ordered.

**Physical Medicine.** In this case, record exactly what type of physical therapy you intend the patient to receive and the number of visits prescribed on this visit. If the therapy includes education on body mechanics, passive modalities or therapeutic exercise, check accordingly. It is also essential that you record the number of visits you have approved. If a lumbar brace is used, mark it accordingly and record the number of days for which it is being recommended.

**Medications.** OTC is for any over-the-counter medication. If you have written a prescription for NSAIDS, fill in this circle. If narcotics or muscle relaxants are used, complete as noted.

**Consultants.** Any consultants ordered on that visit should be recorded.