**Thank you for this referral to *Name of Facility –*** **. The following is a summary of content areas covered (indicated by checked boxes) in sessions with this patient during treatment for their acute low back pain, based on your initial referral of**   /  /    **.**

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| **Patient Information:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Patient Name:** |  | | | | | | | **HICN:** |  | | | | | | | **DOB:** | | /  / | | | | | | | |
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| **Diagnosis Indicating Therapy:** | | | | | |  | | **ICD-10 Code:** | | | | | | | | | | | | |  | | | | | | | | | | |
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| **Referring Physician:** | |  | | | | | | **Start of Care Date:** | | | | | /  / | | | | | |  | | |  |
| **Total # of Visits:** | |  | | |  | | | | | | | |  | |  | | | | | | | | | | | | | |  |
| **Progress Content Areas:**   * **Communication**   Active listening (eye contact, paraphrase/repeat back what patient says)  Facilitation of self-disclosure, activation philosophy (elicit patient’s concerns, discuss and reassure RE: activity)  Patient centered goal-setting / motivational interviewing (connect with patient RE: shared goals)   * **Pain coping skills taught and reinforced**   Relaxed breathing  Adaptive distraction skills (e.g., pleasant place imagery)  Balanced statements to counteract unhelpful thinking styles (e.g., pain catastrophizing, all-or-nothing thinking)   * **Activity-based treatment**   Graded activity (to reduce pain-related activity avoidance)  Graded exposure (to reduce fear-related motion avoidance)   * **Physical impairment component – most appropriate classification (from APTA clinical practice guidelines):**   Acute/subacute LBP with mobility deficits  Acute/subacute LBP with movement coordination impairments  Acute LBP with related (referred) lower extremity pain  Acute/subacute LBP with radiating pain   * **Home exercise program:**   Specific activities integrating pain coping skills (as described above)  Specific education (e.g., web-based format)   * **Treatment monitoring completed: Yes**  **No**   **Additional comments:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **Therapist’s Signature:** | | |  | | | | | | | |  | | | **Date:** | | | **/**    **/** | | | | | | | |
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