Back-2-Wellness PA
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Future Recommendations Questionnaire
For A Medical Cost Projection

In the hopes of creating an accurate Medical Cost Projection, we ask all treating providers to complete this form as thoroughly as possible and return it to the patient's attorney. The future treatment recommendations should only be made for the injuries sustained from the following date of incident.

This is regarding
Patient's Name: _____

Patient's Date of Birth: _____Patient's Date of Incident: _____

Provider's Company/Practice Name: _____

Provider's Name: _____

Provider's Address: _____

Provider's Phone Number: _____

Provider's Contact Name and Email : _____

Please list any future procedures or surgeries that you recommend:

Operation/Procedure: _____
Frequency (E.g. once, 3x/year, etc.) _____
Duration: (E.g. X-Months, X-Years, or patient's lifetime?) _____
Will post-operation/procedure rehab be needed after? _____

Operation/Procedure: _____
Frequency (E.g. once, 3x/year, etc.) _____
Duration: (E.g. X-Months, X-Years, or patient's lifetime?) _____
Will post-operation/procedure rehab be needed after? _____

Please list any future conservative/Therapeutic treatment that you recommend:

Conservative Care: (E.g. Chiropractic/Physical Therapy): _____
Frequency (E.g. 3X/Wk, Monthly, etc.)_____
Duration: (E.g. X-Months, X-Years, or patient's lifetime?) _____

Conservative Care: (E.g. Chiropractic/Physical Therapy): _____
Frequency (E.g. 3X/Wk, Monthly, etc.)_____
Duration: (E.g. X-Months, X-Years, or patient's lifetime?) _____

Please list any future Medications that you recommend:

Medication Name: _____
Dose and Frequency: _____
Duration: (E.g. X-Months, X-Years, or patient's lifetime?) _____

Medication Name: _____
Dose and Frequency: _____
Duration: (E.g. X-Months, X-Years, or patient's lifetime?) _____

Medication Name: _____
Dose and Frequency: _____
Duration: (E.g. X-Months, X-Years, or patient's lifetime?) _____

Medication Name: _____
Dose and Frequency: _____
Duration: (E.g. X-Months, X-Years, or patient's lifetime?) _____

Please list any future Follow-up/Office Visits that you recommend:

Frequency (How often should they come in) _____
Duration: (E.g. X-Months, X-Years, or patient's lifetime?) _____

Please list any Durable Medical Equipment/Supplies that you recommend: (splint, brace, walker, etc.):

DME name & type: _____
Frequency of replacement: _____
Duration to use DME: (Months, Years, or for the patient's lifetime?) _____

DME name & type: _____
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Duration to use DME: (Months, Years, or for the patient's lifetime?) _____

DME name & type: _____
Frequency of replacement: _____
Duration to use DME: (Months, Years, or for the patient's lifetime?) _____

Please list any future Diagnostic studies that you recommend: (x-ray, MRI, CT, EMG/NCV):

Diagnostic Study: _____
Frequency (How often will this study be performed?) _____
Duration: (E.g. X-Months, X-Years, or patient's lifetime?) _____

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Frequency (How often will this study be performed?) _____
Duration: (E.g. X-Months, X-Years, or patient's lifetime?) _____

Please list any other recommendations that you might have that have not been listed, including frequency and duration.

_____

_____

_____

_____ _____

Provider or Provider's representative signature Provider or Provider's representative Printed Name

_____

Date