CHP
SMART SOLUTIONS. HEALTHY RESULTS.

Kaiser Permanente Northwest Treatment Extension Request
(TER to KP Direct Referrals)

Referring Kaiser Clinician:	**Patient Name:**
Treating CHP Provider:	**Kaiser I.D. #:**
Phone:	**Fax:**

Initial KP Referral (Check one): **Chiropractic** **Acupuncture** **Naturopathic**

Initial KP Auth #: **# of Authorized Treatments Used:**

# of treatments this calendar year:

Request for Additional (check one) **Chiropractic** **Acupuncture** **Naturopathic**

# of Additional Treatments Requested (check one) **1** **2** **3** **Dates: _____ to _____**

Initial Complaints and Pain Score(s)/Outcome Assessment Tool:

Initial objective findings:

Diagnosis (must relate to original referral):

Treatment Provided (including number, modalities, exercises, patient education, etc.):

Response to treatment:

Current complaints & Pains Score(s)/Outcome Assessment Tool:

Current objective findings:

Expected outcome/prognosis:

Signature Date

Please complete this form, typed with standard font/typeface. Forward to the Kaiser Permanente Community Medicine Integration Center via fax 877-800-5456**.** Questions about referrals should be directed to 503-813-4560 or 866-813-2437.