

November 14, 2006

Dear Physical Therapist:

The Connecticut Quality Management and Practice (QM&P) Committee is seeking information regarding the impact of direct access in your setting. Please take a moment to complete this questionnaire. This information will be used to refine our new direct access law. All information will remain confidential. Enclosed is a self-addressed envelope for your return.

Please circle or fill in answers and provide comments where appropriate.

1. Number of years of practice in physical therapy _____
2. What year did you first receive your entry level degree in physical therapy? _____

3. Education:

Do you have a certificate in physical therapy?	Yes	No
Do you have a Bachelors degree in physical therapy?	Yes	No
Do you have a Masters degree in physical therapy?	Yes	No
Do you have a doctorate degree in physical therapy?	Yes	No

4. What other degrees/ certifications do you have? _____

5. Under what venue(s) of care are you employed? Circle all that apply. Identify percentages of hours worked.

Acute _____% Outpatient _____% Skilled Nursing/ Sub-acute _____%

Rehab _____% Homecare _____% Pediatrics _____%

Other _____% (please describe)

6. How many individual patients have you treated without a physician referral (direct access) in the last 6 months? _____

7. What percentage of your total patient census was treated without a physical referral within the last 6 months? _____

0-5% 6-10% 10-15% other _____%

8. In the last 6 months, how many patients have your referred to a physician due to the 6-visit or 30 day rule? _____

9. How many of your patients have received reimbursement from third party payors under direct access? _____

Comments:

10. Do you perform Grade V spinal manipulation? Yes No

11. Would it have been helpful for you to be able to refer a patient for diagnostic imaging?

Yes No

Comments:

15. What has hampered your ability to utilize direct access? Please check all that apply

- 6 visit or 30 day rule
- Reimbursement
- Other: _____

General Comments about Direct Access:

Date Completed: _____

Please return to: Quality Management & Practice Committee
 Connecticut Physical Therapy Association
 10 North River Road
 Tolland, CT

Please return by: _____.