

Scoring the Disability of the Arm, Shoulder, and Hand (DASH) Questionnaire:

“The DASH is a 30-item self-report questionnaire designed to measure physical function items, six symptom items, and three social/role function items.”¹ “The DASH is designed to measure physical disability and symptoms in a heterogeneous population that includes both males and females; people who place low, moderate, or high demands on their upper limbs during their daily lives (work, leisure, self-care); and people with a variety of upper-limb disorders.”¹

Scoring

Patients are asked to answer all sections and respond based on their ability to perform activities over the past week; only one answer per question.

At least 27 of the 30 items **must** be completed for scoring.

The assigned values are summed and divided by the number of questions answered. This value is transformed to a score out of 100 by subtracting 1 and multiplying by 25.

$$\text{DASH} = \left\{ \frac{\text{sum of } n \text{ responses}}{n} - 1 \right\} \times 25 \quad n = \text{total number of questions answered}$$

Minimum detectable change (MDC): 12.7 points; current literature holds 12.7 points to be the minimal change in score to be statistically significant at the 95% confidence interval.²

Minimum clinically important difference (MCID): 15 points; this represents the change in score needed to be considered clinically significant.²

¹Solway S, Beaton DE, McConnell S, Bombardier C. The DASH Outcome Measure User’s Manual, Second Ed. Toronto, Ontario: Institute for Work and Health, 2002.

²Beaton DE, Davis AM, Hudak P, McConnell S. The DASH (Disabilities of the Arm, Shoulder, and Hand) outcome measure: What do we know about it now? British Journal of Hand Therapy 2001; 6(4):109-118.

Please visit the DASH website at www.dash.iwh.on.ca for further references.

OptumHealth* recommends an outcome measure be completed on the initial submission (**baseline**), requests for additional services (**response to treatment**), and at patient discharge (**effectiveness of intervention**).

Patient Summary Form

Instructions: Please complete this form within the specified timeframe and fax to the specified fax number as indicated on this Summary or your information previously provided. *Fax number may vary by plan.

Patient Information (PST-702 (Rev. 1/16/2020))

Patient's Name: Last, First, MI, Male, Female, Patient's Date of Birth

Patient's Address: City, State, Zip Code

Patient's Insurance: Health Plan, Group Number

Referring Physician (if applicable), Date Referral Issued (if applicable), Referral Number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form), 2. Federal Tax ID (EIN) of entity in box #1

3. Name and credentials of the individual performing the service(s), 4. NPI of entity in box #1, 5. NPI of entity in box #1, 6. Phone #

7. Address of the billing provider or facility indicated in box #1, 8. State, 9. Zip Code

Provider Completes This Section:

Date you want FMS submission to begin: [] [] [] [] [] []

Patient Type

New to your office
 Est'd, new injury
 Est'd, new episode
 Est'd, continuing care
 Other

Nature of Condition

Initial onset (within last 3 months)
 Recurrent (multiple episodes of < 3 months)
 Chronic (continuous duration > 3 months)

ICD ONLY Anticipated CMT Level

98940 98942 98941 98943

Current Functional Measure Score

Neck Index: DASH (other)

Back Index: LEFS (other)

Patient Completes This Section:

Please fill in selections completely. Symptoms began on: [] [] [] [] [] []

Indicate where you have pain or other symptoms:

1. Briefly describe your symptoms: _____

2. How did your symptoms start? _____

3. Average pain intensity:
 Last 24 hours: no pain (0) 1 2 3 4 5 6 7 8 9 10 worst pain
 Past week: no pain (0) 1 2 3 4 5 6 7 8 9 10 worst pain

4. How often do you experience your symptoms?
 Constantly (76%-100% of the time) Frequently (51%-75% of the time) Occasionally (26% - 50% of the time) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and household).
 Not at all A little bit Moderately Quite a bit Extremely

6. How is your condition changing, since care began at this facility? _____

Insert Score Here

DISABILITIES OF THE ARM, SHOULDER AND HAND

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Write.	1	2	3	4	5
3. Turn a key.	1	2	3	4	5
4. Prepare a meal.	1	2	3	4	5
5. Push open a heavy door.	1	2	3	4	5
6. Place an object on a shelf above your head.	1	2	3	4	5
7. Do heavy household chores (e.g., wash walls, wash floors).	1	2	3	4	5
8. Garden or do yard work.	1	2	3	4	5
9. Make a bed.	1	2	3	4	5
10. Carry a shopping bag or briefcase.	1	2	3	4	5
11. Carry a heavy object (over 10 lbs).	1	2	3	4	5
12. Change a lightbulb overhead.	1	2	3	4	5
13. Wash or blow dry your hair.	1	2	3	4	5
14. Wash your back.	1	2	3	4	5
15. Put on a pullover sweater.	1	2	3	4	5
16. Use a knife to cut food.	1	2	3	4	5
17. Recreational activities which require little effort (e.g., cardplaying, knitting, etc.).	1	2	3	4	5
18. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5
19. Recreational activities in which you move your arm freely (e.g., playing frisbee, badminton, etc.).	1	2	3	4	5
20. Manage transportation needs (getting from one place to another).	1	2	3	4	5
21. Sexual activities.	1	2	3	4	5

DISABILITIES OF THE ARM, SHOULDER AND HAND

g) the past week, to what extent has your arm, shoulder or hand problem interfered with your normal activities with family, friends, neighbours or groups? (circle number)

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
1	1	2	3	4	5

g) the past week, were you limited in your work or regular daily activities as a result of your arm, shoulder or hand problem? (circle number)

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
1	1	2	3	4	5

the severity of the following symptoms in the last week. (circle number)

	NONE	MILD	MODERATE	SEVERE	EXTREME
shoulder or hand pain.	1	2	3	4	5
shoulder or hand pain when you need any specific activity.	1	2	3	4	5
tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5
stiffness in your arm, shoulder or hand.	1	2	3	4	5
swelling in your arm, shoulder or hand.	1	2	3	4	5

g) the past week, how much difficulty have you had doing because of the pain in your arm, shoulder or hand? (circle number)

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
1	1	2	3	4	5

30. I feel less capable, less confident or less useful because of my arm, shoulder or hand problem. (circle number)

	STRONGLY DISAGREE	DISAGREE	NEITHER AGREE NOR DISAGREE	AGREE	STRONGLY AGREE
1	1	2	3	4	5

DASH DISABILITY/SYMPTOM SCORE = $\frac{73}{30} - 1$ (sum of n responses / n) - 1 x 25, where n is the number of completed responses.)

A DASH score may not be calculated if there are greater than 3 missing items.

$$DASH = \left\{ \frac{\text{sum of } n \text{ responses}}{n} - 1 \right\} \times 25$$

$$DASH = \left\{ \frac{73}{30} - 1 \right\} \times 25 = 35.83\%$$