ORTHOPEDIC RESTORATIVE MASSAGE

PRESCRIPTION / LETTER OF REFERRAL

"THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY"

DATE __ / __ / __

PATIENT ____

PHYSICIAN ____________________ ADDRESS ____________________

PHONE ____________________ FAX ____________________

REFERRED TO ____________________ PHONE ____________________

Any of the following Physicians' Current Procedural Terminology, CPT procedures and / or modalities, which are within this therapists' scope of practice, training, & / or State & / or Patient's Insurance Policy regulations, may be used as therapist deems necessary during any treatment session. Normally four procedure units & 2 max modalities allowed per visit. A Unit = 15 minute segments of time. Conditions or prescription may require more units.

PROCEDURES and MODALITIES

- 97010 ☐ HOT/COLD PACKS (as necessary)
- 97112 ☐ NEUROMUSCULAR RE-EDUCATION
- 97140 ☐ MYOFASCIAL RELEASE
- 97039 ☐ UNLISTED MODALITY, by report
- 97124 ☐ MASSAGE THERAPY
- 97139 ☐ UNLISTED PROCEDURE, by report
- 97140 ☐ MANUAL THERAPY TECHNIQUES

PHYSICIAN'S ICD - 10 DIAGNOSIS OF PATIENT

(please provide Dx Codes)

- _____ ☐ MIGRAINES
- _____ ☐ HEADACHES
- _____ ☐ CERVICAL, Inc. Whiplash Injury Sprain / Strain
- _____ ☐ JAW (TMJ & Ligament) Sprain / Strain R ☐ L ☐
- _____ ☐ CERVICALGIA (pain in neck)
- _____ ☐ INFRASPINATUS Sprain / Strain R ☐ L ☐
- _____ ☐ SUBSCAPULARIS Sprain / Strain (muscle) R ☐ L ☐
- _____ ☐ SUPRASPINATUS Sprain / Strain (muscle) R ☐ L ☐
- _____ ☐ SHOULDER & ARM (unspecified site) R ☐ L ☐
- _____ ☐ ELBOW & FOREARM (unspecified site) R ☐ L ☐
- _____ ☐ WRIST Sprain / Strain (unspecified site) R ☐ L ☐
- _____ ☐ CARPAL TUNNEL SYNDROME R ☐ L ☐
- _____ ☐ HAND Sprain / Strain (unspecified site) R ☐ L ☐
- _____ ☐ PAIN IN THORACICSPINE
- _____ ☐ THORACIC (DORSAL) Sprain / Strain
- _____ ☐ LUMBAR Sprain / Strain
- _____ ☐ PELVIS (unspecified site) Sprain / Strain
- _____ ☐ HIP & THIGH (upspecified site)
- _____ ☐ SACROILIAC REGION (unspecified site) Spr/Str
- _____ ☐ SACRUM Sprain / Strain
- _____ ☐ LUMBOSACRAL RADICULITIS R ☐ L ☐
- _____ ☐ SCIATICA (neuralgia, neuritis) R ☐ L ☐
- _____ ☐ KNEE OR LEG Sprain/Strain R ☐ L ☐
- _____ ☐ ANKLE (unspecified site) Sprain/Strain R ☐ L ☐
- _____ ☐ Foot (unspecified site) Sprain/Strain R ☐ L ☐
- _____ ☐ MYOFIBROSIS; muscles, ligament, fascia
- _____ ☐ SPASM OF MUSCLE ____________
- _____ ☐ MYALGIA & MYOSITIS (Fibromyositis)
- _____ ☐ Unspecified Disorder of Muscle, Ligament, Fascia
- _____ ☐ ______________________________

Times Per Week: _______ for _______ Weeks, OR Times Per Month: _______ for _______ Months, or Total Visit This Script ______

Patient to return or call, prior to renewal of prescription

PLAN OF CARE/COMMENTS:

____

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PHYSICIAN'S SIGNATURE: ____________________ NPI#: ____________

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