PRESCRIPTION / LETTER OF REFERRAL

## THE FOLLOWING PRESCRIBED DX & TX is “MEDICALLY NECESSARY”

**DATE** / /

## PATIENT

**PHYSICIAN** \_ \_ **ADDRESS**

**PHONE**: \_ **FAX**: \_ **Email:** \_ **REF TO** *\_* **Ph***: \_ \_***Lic: NPI***\_ \_* **CO: Email: FAX: \_ \_**

**Any of the following Physician’s *Current Procedural Terminology,* CPT™ Procedures and / or Modalities, that are within this Therapist’s Scope of Practice,**

**Training and State License or Certification & Patient’s Insurance Policy Regulations may be used as therapist deems necessary during any treatment session. Normally up to maximum 4 procedure units and 2 modality units allowed per visit. A Unit = 15 - minutes. Or as conditions per prescription may require.**

# PHYSICAL MEDICINE PROCEDURES and MODALITIES

97010 ☐ HOT/COLD PACKS (as necessary)

97014 ☐ ELECTRICAL STIMULATION, un-attended

97018 ☐ PARAFFIN BATH

97022 ☐ WHIRLPOOL

97026 ☐ INFRARED

97032 ☐ ELECTRICAL STIMULATION, attended

97034 ☐ CONTRAST BATHS

97035 ☐ ULTRASOUND

97036 ☐ HYDROTHERAPY (full immersion) 97124 ☐ MASSAGE THERAPY

97139 ☐ UNLISTED PROCEDURE, by report

97140 ☐ MANUAL THERAPY TECHNIQUES

97799 ☐ Unlisted Physical Medicine Rehab Services or Procedure (By Report) **(EX: Initial Visit Assessment**)

\_ ☐ OTHER

\_ ☐ OTHER

☐ MIGRAINES

# PHYSICIAN’S ICD- 10 DIAGNOSIS OF PATIENT

☐ LUMBAR Sprain / Strain

☐ HEADACHES ☐ PELVIS (unspecified site) Sprain / Strain

☐ CERVICAL, Inc. Whiplash Injury Sprain / Strain ☐ HIP & THIGH (unspecified site)

☐ JAW (TMJ & Ligament) Sprain /Strain R L ☐ SACROILIAC REGION (unspecified site) Sprain /Strain

☐ CERVICALGIA (pain in neck) ☐ SACRUM Sprain / Strain

☐ INFRASPINATUS Sprain / Strain R L ☐ LUMBOSACRAL RADICULITIS R \_ L\_

☐ SUBSCAPULARIS Sprain /Strain (muscle) R\_

☐ SUPRASPINATUS Sprain/ Strain (muscle) R\_

☐ SHOULDER & ARM (unspecified site) R

☐ ELBOW & FOREARM (unspecified site) R

L ☐ SCIATICA (neuralgia, neuritis) R \_ L \_

L ☐ KNEE OR LEG Sprain/Strain R \_ L \_

L ☐ ANKLE (unspecified site) Sprain/Strain R \_ L \_

L \_☐ FOOT (unspecified site) Sprain/Strain R \_ L \_

☐ WRIST Sprain / Strain (unspecified site) R \_ L ☐ MYOFIBROSIS; muscles, ligament, fascia

☐ CARPAL TUNNEL SYNDROME R

☐ HAND Sprain / Strain (unspecified site) R

L \_☐ SPASM OF MUSCLE

L ☐ MYALGIA & MYOSITIS (Fibro myositis)

☐ PAIN IN THORACIC SPINE ☐ Unspecified Disorder of Muscle, Ligament, Fascia

☐ THORACIC (DORSAL) Sprain / Strain ☐

**Times Per Week: \_\_\_\_\_\_\_ for \_\_\_\_\_ Weeks, OR Times Per Month: \_\_\_\_\_\_\_ for \_\_\_\_\_\_\_\_\_\_Months or Total Visits This Script \_\_\_\_\_\_\_\_\_**

Patient to return or call, prior to renewal of prescription

PLAN OF CARE / PHYSICIAN’S COMMENTS:

**NOTES: 1.** Only treating physician may enter or check Diagnoses Codes**. 2.** Any claim to insurance company or attorney that indicates a diagnosis or DX Code(s)

MUST have a signed, written prescription by treating physician or therapist is practicing medicine without a license and would be subject to state massage license being revoked and/or other possible legal ramifications**. 3.** Only physician may modify this prescription form with exception of Patient, Physician, Therapist & Procedures & Modality Sections**. 4.** LMTs may NEVER use physician’s NPI or other identifying information when filing claims. Therapists must sign daily notes.

**PHYSICIAN'S SIGNATURE: \_ NPI #: \_**

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