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 _____

PHYSICIAN'S ICD- 10 DIAGNOSIS OF PATIENT

_____☐ 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 THORACIC SPINE
_____☐ THORACIC (DORSAL) Sprain / Strain
_____ ☐ LUMBAR Sprain / Strain
_____ ☐ PELVIS (unspecified site) Sprain / Strain
_____ ☐ HIP & THIGH (unspecified site)
_____ ☐ SACROILIAC REGION (unspecified site) Sprain /Strain
_____ ☐ 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 (Fibro myositis)
_____ ☐ Unspecified Disorder of Muscle, Ligament, Fascia
_____ ☐ _____

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 #:** _____