DRAGONFLY Medical Massage Therapy

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PRESCRIPTION / LETTER OF REFERRAL

"THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY"

Patient Name: _____ Date: _____/_____/_____
Physician Name: _____
Phone #: _____ Fax #: _____
Address: _____
City: _____ State: _____ Zip: _____

Referred to: _____ Phone #: _____

Any of the following Physicians' *Current Procedural Terminology*, CPT™ procedures and / or modalities, which are within this therapists' scope of practice, and training, and / or State Licensing and / or Patient's Insurance Policy regulations, may be used as therapist deems necessary during any treatment session. Normally 4 procedure units are allowed per visit and 2 modalities. A Unit = 15 minute segments of time. Conditions or prescription may require more units.

97010	☐	HOT/COLD PACKS (as necessary)	97039	☐	UNLISTED MODALITY, by report
97014	☐	ELECTRIC STIMULATION, un-attended	97036	☐	HYDROTHERAPY (full immersion)
97018	☐	PARAFFIN BATH	**97124**	☒	**MASSAGE THERAPY**
97022	☐	WHIRLPOOL	97139	☐	UNLISTED PROCEDURE, by report
97026	☐	INFRA-RED	**97140**	☒	**MANUAL THERAPY TECHNIQUES**
97032	☐	ELECTRICAL STIMULATION, attended	97749	☐	INITIAL ASSESSMENT /EVALUATION
97034	☐	CONTRAST BATHS	97799	☐	Unlisted Physical Medicine Rehab Service or Procedure ie; Laser Therapy (By Report)
97035	☐	ULTRASOUND			

ICD-10		Description		ICD-10		Description	
_____	☐	MIGRAINES		_____	☐	LUMBAR Sprain/Strain	
_____	☐	HEADACHES		_____	☐	PELVIS (unspecified site) Sprain/Strain	
_____	☐	CERVICAL, incl. Whiplash Injury Sprain/Strain		_____	☐	HIP & THIGH (unspecified site)	
_____	☐	CERVICALGIA (pain in neck)		_____	☐	SACROILIAC REGION (unspecified site)	
_____	☐	JAW TMJ (& Ligament) Sprain/Strain	R L	_____	☐	SACRUM Sprain/Strain	
_____	☐	INFRASPINATUS Sprain/Strain	R L	_____	☐	LUMBOSACRAL RADICULITIS	R L
_____	☐	SUPRASPINATUS Sprain/Strain (muscle)	R L	_____	☐	SCIATICA (neuralgia, neuritis)	R L
_____	☐	SHOULDER & ARM (unspecified site)	R L	_____	☐	KNEE OR LEG Sprain/Strain	R L
_____	☐	ELBOW & FOREARM (unspecified site)	R L	_____	☐	ANKLE (unspecified site) Sprain/Strain	R L
_____	☐	WRIST Sprain/Strain (unspecified site)	R L	_____	☐	FOOT (unspecified site) Sprain/Strain	R L
_____	☐	CARPAL TUNNEL SYNDROME	R L	_____	☐	PAIN IN THORACIC SPINE	
_____	☐	HAND Sprain / Strain (unspecified site)	R L	_____	☐	SPASM OF MUSCLE	
_____	☐	MYOFIBROSIS muscles, ligament, fascia		_____	☐	MYALGIA & MYOSITIS (Fibromyositis)	
_____	☐	Unspecified Muscle Disorder, Ligament, Fascia		_____	☐	THORACIC (DORSAL) Sprain/Strain	
Other	☐	_____		Other	☐	_____	
Other	☐	_____		Other	☐	_____	

Times Per Week: _____ for _____ Weeks, OR _____ Times Per Month: _____ for _____ Months, or Total Visits This Script _____

Patient must return or call before a prescription will be renewed.

PLAN OF CARE / COMMENTS: _____

PHYSICIAN'S SIGNATURE: _____ NPI #: _____ DATE: _____/_____/_____