PHYSICIAN'S PRESCRIPTION / REFERRAL / MEDICAL NECESSITY

FROM DOCTOR: _____NPI#:_____DATE:_____

PHONE:_____ FAX: _____ ADDRESS:_____

TO THERAPIST: **Nanci Williams, LMT 14787; Re-Member Massage LLC**

PHONE: **503-939-9123** FAX: **503-530-8174**

ADDRESS: **1675 SW Marlow Ave, Suite 307D, Portland OR 97225**

REGARDING PATIENT:_____

TREATMENT IS MEDICALLY NECESSARY to assist in healing from injuries sustained _____MVA. Please treat the patient for, diagnoses indicated below, using the modalities/procedures check marked below that are within your scope of practice.

MODALITIES / PROCEDURES

91036_____HYDROTHERAPY (ATTENDED)
91110_____THERAPEUTIC EXERCISE (R.O.M.)
91112_____NEUROMUSCULAR RE-EDUCATION
97122_____MANUAL TRACTION
97124__X__ MASSAGE THERAPY **
97140__X__MANUAL THERAPY TECHNIQUES**
97250_____MYOFASCIAL RELEASE
97530_____THERAPEUTIC ACTIVITY

DX CODES (ICD10 updated please)

_____CARPAL TUNNEL SYNDROME
_____CERVICALGIA
_____UPPER EXTREMITIES: BRACHIAL, NEURITIS / RADICULITIS
_____SCIATICA
_____LUMBOSACRAL / THORACIC NEURITIS OR RADICULITIS (Lower Extremities)
_____FIBROMYALGIA / MYALGIA / MYOSITIS
_____HEADACHE
_____SHOULDERS UPPER ARMS SPRAIN/STRAIN
_____LUMBOSACRAL SPRAIN / STRAIN
_____CERVICAL SPRAIN / STRAIN
_____THORACIC SPRAIN / STRAIN
_____LUMBAR SPRAIN / STRAIN
_____SACRAL SPRAIN / STRAIN
_____COCCYX SPRAIN / STRAIN
_____T.M.J. SPRAIN / STRAIN

OTHER DX CODES w/ Description

1._____ _____
2._____ _____
3._____ _____
4._____ _____

 # OF VISITS _____ **# OF TIMES PER WEEK** _____ **# OF WEEKS** _____

CLAIM #_____ INSURANCE _____ PHONE# _____

ADDRESS_____

PHYSICIAN'S SIGNATURE _____

SPECIAL NOTES_____