 4517 N. Western Ave, Oklahoma City, OK , 73118
 Phone number : (405)-293-3655 FAX (833)944-2529
 Email : organicabodyworks@gmail.com

**PRESCRIPTION / LETTER OF REFERRAL**

***“****THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY”*

DATE: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**PATIENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** PHYSICIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

PROCEDURES and MODALITIES

97014 ELECTRIC STIMULATION, un-attended 97036 HYDROTHERAPY (full immersion)

97039 UNLISTED MODALITY, by report 97124 MASSAGE THERAPY
97139 UNLISTED PROCEDURE, by report 97140 MANUAL THERAPY TECHNIQUES

97799 Unlisted Physical Medicine Rehab Procedure (By Report) Service or \_\_\_\_\_ OTHER \_\_\_\_

97018 PARAFFIN BATH 97022 WHIRLPOOL
97026 INFRA-RED 97032 ELECTRICAL STIMULATION, attended

97034   CONTRAST BATHS 97035   ULTRASOUND

**PHYSICIAN’S DIAGNOSIS OF PATIENT**

346.0 MIGRAINES 784.0 HEADACHES
847.0 CERVICAL, Inc. Whiplash Injury Sprain / Strain 848.1 JAW (TMJ and Ligament) Sprain /Strain R \_\_ L \_\_
723.1 CERVICALGIA (pain in neck) 840.3 INFRASPINATUS Sprain / Strain R \_\_ L \_\_

840.5   SUBSCAPULARIS Sprain /Strain (muscle) R\_\_ L\_\_ 840.6   SUPRASPINATUS Sprain/ Strain (muscle) R \_\_ L \_\_

840.9 SHOULDER and ARM (unspecified site) R\_\_ L\_\_ 841.9 ELBOW and FOREARM (unspecified site) R \_\_ L \_\_

842.00 WRIST Sprain / Strain (unspecified site) R\_\_ L\_\_ 354.0 CARPAL TUNNEL SYNDROME R \_\_ L \_\_

842.10 HAND Sprain / Strain (unspecified site) R\_\_ L\_\_ 724.1 PAIN IN THORACIC SPINE

847.1   THORACIC (DORSAL) Sprain / Strain 847.2  LUMBAR Sprain / Strain

848.9 PELVIS (unspecified site) Sprain / Strain 843.9 HIP and THIGH (unspecified site)
846.9 SACROILIAC REGION (unspecified site) Spr/Str 847.3 SACRUM Sprain / Strain

724.4 LUMBOSACRAL RADICULITIS R \_ L\_ 724.3 SCIATICA (neuralgia, neuritis) R\_\_ L\_\_

844.9 KNEE OR LEG Sprain/Strain R \_\_ L \_\_ 845.00 ANKLE (unspecified site) Sprain/Strain R \_\_ L \_\_

845.10 FOOT (unspecified site) Sprain/Strain R\_\_ L\_\_ 728.2 MYOFIBROSIS; muscles, ligament, fascia
728.85 SPASM OF MUSCLE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 729.1 MYALGIA and MYOSITIS (Fibromyositis)
728.9 Unspecified Disorder Of Muscle, Ligament, Fascia Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 /COMMENTS:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

PHYSICIAN'S SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_