Massage Therapy Prescription / Referral Form

FROM: Doctor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TO: Virginia Medical Massage  
1421 Kempsville Rd, Ste C  
Chesapeake VA 23320  
Phone: 757-410-5322  
Fax: 757-548-0670  
  
Regarding Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TREATMENT IS MEDICALLY NECESSARY.  
Please treat the patient for diagnoses listed below, using modalities / procedures marked below that are within your scope of practice.**

**Condition related to:**

**Diagnosis Codes:**   
  
**Modalities/Procedures (CPT)**

\_\_\_97124 Massage Therapy  
\_\_\_97140 Manual Therapy- Including Lymphatic, PTSD treatments  
\_\_\_97110 Therapeutic Exercises/Stretching

**Duration and Frequency of Treatment**

4 or 6 units, \_\_\_ time(s) per week for \_\_\_ weeks. OR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Treatment Goals**   
\_\_ Decrease Pain  
\_\_ Decrease Inflammation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
\_\_ Decrease Muscle Tension / Spasms \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
\_\_ Increase Mobility / Range of Motion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Other Instructions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Dr. Signature