PRESCRIPTION / LETTER OF REFERRAL

"THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY"

DATE _____/_____/_____

PATIENT _____

PHYSICIAN _____ **ADDRESS** _____

PHONE _____ **FAX**: _____

REFERRED TO: _____ **Phone**: _____

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

PROCEDURES and MODALITIES

97010 ☐ HOT/COLD PACKS (as necessary)
97014 ☐ ELECTRIC STIMULATION, un-attended
97018 ☐ PARAFFIN BATH
97022 ☐ WHIRLPOOL
97026 ☐ INFRA-RED
97032 ☐ ELECTRICAL STIMULATION, attended
97034 ☐ CONTRAST BATHS
97035 ☐ ULTRASOUND
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 ……
Service or Procedure (By Report) (Initial or Re Assessment
_____ ☐ 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) Spr/Str
_____ ☐ 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 (Fibromyositis)
_____ ☐ 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 / COMMENTS:

_____
_____
_____

PHYSICIAN'S SIGNATURE: _____ **NPI #:** _____