MEDICAL MASSAGE TREATMENT
MIND, BODY AND SOLE - MASSAGE THERAPY
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PHYSICIAN'S PRESCRIPTION OF MEDICAL NECESSITY

REFERRING PHYSICIAN: _____
PHONE: _____

ADDRESS: _____
FAX: _____
Dr. LICENSE #:_____

REGARDING PATIENT_____, TREATMENT IS MEDICALLY NECESSARY. Please treat the patient for diagnoses indicated below, using the modalities/procedures check marked below that are within your scope of practice:

MODALITIES/PROCEDURES

97010__ HOT OR COLD PACK
97110__ THERAPUTIC EXERCSE (R.O.M)
97124__ MASSAGE THERAPY
97032__ ELECTRICAL STIMULTION (MANUAL/ATTENDED)
97530__ THERAPUTIC ACTIVITY

DX CODES

354.0__ CARPAL TUNNEL SYNDROME
723.1__ CERVICALGIA
723.4__ BRACHIAL NEURITIS/RADICULITIS (Upper Extremities)
724.3__ SCIATICA
724.4__ LUMBOSACRAL/THORACIC NEURITIS OR RADICULITIS (Lower Extremities)
729.1__ FIBROMYALGIA / MYALGIA / MYOSITIS
784.0__ HEADACHE
840.9__ SHOULDER-UPPER ARMS SPRAIN/STRAIN
846.0__ LUMBOSACRAL SPRAIN / STRAIN
847.0__ CERVICAL SPRAIN / STRAIN
847.1__ THORACIC SPRAIN / STRAIN
847.2__ LUMBAR SPRAIN / STRAIN
847.3__ SACRAL SPRAIN / STRAIN
847.4__ COCCYX SPRAIN/ STRAIN
848.1__ T.M.J. SPRAIN / STRAIN
OTHER DX CODES 1._____ 2._____ 3. _____

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

SPECIAL NOTES: _____
_____

DR. SIGNATURE:_____ DATE: _____