# PRESCRIPTION / LETTER OF REFERRAL

**"THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY"**

DATE _____/_____/_____

**PATIENT** _____

**PHYSICIAN** _____ **ADDRESS:** _____

**PHONE** _____ **FAX**: _____

**REFERRED TO**: ***IDAHO MEDICAL MASSAGE*** **Phone***: (208) 248-6418* **NPI:** *1073323176*

**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)
97018 ☐ PARAFFIN BATH
97124 ☐ MASSAGE THERAPY
97140 ☐ MANUAL THERAPY TECHNIQUES
☐ 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 #:** _____