PRESCRIPTION/LETTER OF REFERRAL

Date _____/_____/_____

PATIENT NAME: _____
PHYSICIAN: _____ PHONE: _____
REFERRED TO: _**Idaho Medical Massage** _ PHONE: _ **(208) 244-0941**__ NPI #: _**1073323176**___

The therapist may provide only physician-prescribed CPT-coded procedures and modalities that are within scope of practice, licensure, training, and the patient's insurance policy, and that are medically necessary and supported by documentation. Treatment is limited to up to four (4) timed procedure units per visit (15 minutes per unit) and up to two (2) modalities per visit, unless additional services are specifically authorized by the prescription or supported by documented medical necessity consistent with payer guidelines.

PHYSICIAN DIAGNOSIS OF PATIENT

_____ MIGRAINES
_____HEADACHES
_____CERVICAL: Whiplash/ Injury/ Sprain/ Strain
_____JAW: TM & Ligament/ Sprain /Strain R __ L __
_____CERVICALGIA (Pain in Neck)
_____INFRASPINATUS: Sprain/ Strain 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
_____OTHER: _____

_____LUMBAR: Sprain/ Strain
_____PELVIS: Sprain/ Strain (unspecified site)
_____HIP & THIGH: (unspecified site)
_____SACROILIAC REGION: (unspecified site)
_____SACRUM: Sprain/ Strain
_____LUMBAROSACRAL RADICULITIES R __ L __
_____SCIATICA: (neuralgia, neuritis) R __ L __
_____KNEE OR LEG: Sprain/ Strain R __ L __
_____ANKLE: Sprain/ Strain (unspecified site) R __ L __
_____FOOT: Sprain/ Strain (unspecified site) R __ L __
_____MYOFIBROSIS: (muscles, ligaments, fascia)
_____SPASM OF MUSCLE: _____
_____MYALGIA & MYOSITIS
_____UNSPECIFIED MUSCLE DISORDER, LIGAMENT, FASCIA
_____OTHER: _____

PRESCRIBED PROCEDURES, MODALITIES, & CPT CODES

- ☐ 97124 MASSAGE THERAPY
- ☐ 97140 MANUAL THERAPY TECHNIQUES (myofascial release, trigger point therapy, manual lymphatic drainage)
- ☐ 97010 HOT/COLD PACKS (as adjunctive therapy)
- ☐ 97018 PARAFIN BATH
- ☐ 97034 CONTRAST BATHS
- ☐ 97749 INITAIAL ASSESSMENT/ EVALUATION

FREQUENCY/DURATION

	TIMES PER:	FOR WEEKS	MONTHS
WEEKLY			

PLAN OF CARE/COMMENTS

_____
_____

PHYSICIAN CERTIFICATION & AUTHORIZATION

I certify that the above treatment plan is medically necessary and appropriate for the diagnosed condition(s). I authorize massage and manual therapy treatments as outlined above.

Physician's Signature: _____ License #: _____
NPI #: _____