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, and training, and / or State Licensing and / or Patient's Insurance Policy regulations, may be used as therapist deems necessary during any treatment session. Normally 4 procedure units are allowed per visit and 2 modalities. A Unit = 15 minute segments of time. Conditions or prescription may require more units.

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
97039	☐	UNLISTED MODALITY, by report
97036	☐	HYDROTHERAPY (full immersion)
97124	☐	MASSAGE THERAPY
97139	☐	UNLISTED PROCEDURE, by report
97140	☐	MANUAL THERAPY TECHNIQUES
97749	☐	Initial Assessment /Evaluation
97799	☐	Unlisted Physical Medicine Rehab Service or Procedure ie; Laser Therapy (By Report)

PROCEDURES and MODALITIES

PHYSICIAN'S DIAGNOSIS OF PATIENT

ICD-10		Description		
_____	☐	MIGRAINES		
_____	☐	HEADACHES		
_____	☐	CERVICAL, Inc. 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		

ICD-10		Description		
_____	☐	LUMBAR Sprain / Strain		
_____	☐	PELVIS (unspecified site) Sprain / Strain		
_____	☐	HIP & THIGH (unspecified site)		
_____	☐	SACROILIAC REGION (unspecified site)		
_____	☐	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 Muscle Disorder, Ligament, Fascia		

Other ☐_____

Other ☐_____

Other ☐_____

Other ☐_____

Other ☐_____

Other ☐_____

Times Per Week:_____for_____Weeks, OR Times Per Month:_____for_____Months, or Total Visits This Script _____

Patient to return or call, prior to renewal ofprescription

PLAN OF CARE / COMMENTS:

PHYSICIAN'S SIGNATURE:__NPI #: __