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)	97039	☐	UNLISTED MODALITY, by report
97014	☐	ELECTRIC STIMULATION, un-attended	97036	☐	HYDROTHERAPY (full immersion)
97018	☐	PARAFFIN BATH	97124	☐	MASSAGE THERAPY
97022	☐	WHIRLPOOL	97139	☐	UNLISTED PROCEDURE, by report
97026	☐	INFRA-RED	97140	☐	MANUAL THERAPY TECHNIQUES
97032	☐	ELECTRICAL STIMULATION, attended	97749	☐	Initial Assessment /Evaluation
97034	☐	CONTRAST BATHS	97799	☐	Unlisted Physical Medicine Rehab Service or Procedure ie; Laser Therapy (By Report)
97035	☐	ULTRASOUND			

PROCEDURES and MODALITIES

PHYSICIAN'S DIAGNOSIS OF PATIENT

ICD-10		Description			ICD-10		Description		
_____	☐	MIGRAINES			_____	☐	LUMBAR Sprain / Strain		
_____	☐	HEADACHES			_____	☐	PELVIS (unspecified site) Sprain / Strain		
_____	☐	CERVICAL, Inc. Whiplash Injury Sprain / Strain			_____	☐	HIP & THIGH (unspecified site)		
_____	☐	JAW TM } & Ligament) Sprain /Strain	R	L	_____	☐	SACROILIAC REGION (unspecified site)		
_____	☐	CERVICALGIA (pain in neck)			_____	☐	SACRUM Sprain / Strain		
_____	☐	INFRASPINATUS Sprain / Strain	R	L	_____	☐	LUMBOSACRAL RADICULITIS	R	L
_____	☐	SUPRASPINATUS Sprain/ Strain (muscle)	R	L	_____	☐	SCIATICA (neuralgia, neuritis)	R	L
_____	☐	SHOULDER & ARM (unspecified site)	R	L	_____	☐	KNEE OR LEG Sprain/Strain	R	L
_____	☐	ELBOW & FOREARM (unspecified site)	R	L	_____	☐	ANKLE (unspecified site) Sprain/Strain	R	L
_____	☐	WRIST Sprain / Strain (unspecified site)	R	L	_____	☐	FOOT (unspecified site) Sprain/Strain	R	L
_____	☐	CARPAL TUNNEL SYNDROME	R	L	_____	☐	MYOFIBROSIS muscles, ligament, fascia		
_____	☐	HAND Sprain / Strain (unspecified site)	R	L	_____	☐	SPASM OF MUSCLE_____		
_____	☐	PAIN IN THORACIC SPINE			_____	☐	MYALGIA & MYOSITIS (Fibromyositis)		
_____	☐	THORACIC (DORSAL) Sprain / Strain			_____	☐	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 of prescription

PLAN OF CARE / COMMENTS:

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