PRESCRIPTION / LETTER OF REFERRAL

"THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY"
DATE:___/___/___

Patient:_____

Physician:_____Phone:_____

Address:_____

Referred to: Vitality Therapeutic Massage & Yoga

Any of the following Physicians Current Procedural Terminology, CPT procedures and/or modalities, that are within this therapists scope of practice, and training,& state &/or Patients Insurance Policy regulations, may be used as therapist deems necessary during any treatment session. Normally four units allowed per visit. A unit= 15 minute segments of time. Conditions or prescriptions may require more units.

PROCEDURES and MODALITIES

97010 ___ HOT PACKS (as necessary)
97124 ___ MASSAGE THERAPY
97140 ___ MANUAL THERAPY TECHNIQUES

PHYSICIAN'S DIAGNOSIS OF PATIENT

S13.8XXA ___ CERVICAL, Includes whiplash Spr/Str **S43.80XA** ___ INFRASPINATUS Spr/Str R/L **S43.80XA** ___ SUBSCAPULARIS Spr/Str R/L **S63.509A** ___ WRIST Spr/Str (Unspecified site) R/L **S23.3XXA** ___ THORACIC (DORSAL) Spr/Str **S33.8XXA** ___ SACRUM Spr/Str

S73.109A ___ HIP & THIGH (Unspecified site) Spr/Str **S93.409A** ___ ANKLE (Unspecified site) Spr/Str R/L

G43.909 ___ MIGRAINES
T14.90 ___ PELVIS (unspecified site) Spr/Str

M54.17 ___ LUMBOSACRAL RADICULITIS R/L **M62.50** ___ MYELOFIBROSIS: Muscles, Ligaments, Fascia

M54.2 ___ CERVICALGIA (Pain in Neck)

S03.4XXA ___ JAW (TMJ & Ligament) Spr/Str R/L **S43.409A** ___SHOULDER & ARM (Unspecified site) R/L

S53.409A ___ ELBOW & FOREARM (Unspecified site) R/L **S63.90XA** ___ HAND Spr/Str (Unspecified site) R/L
S33.5XXA ___ LUMBAR Spr/Str

S83.90XA ___ KNEE OR LEG Spr/Str R/L **S33.9XXA** ___ SACROILIAC REGION R/L

S93.609A___ FOOT (Unspecified site) Spr/Str R/L **G56.00** ___ CARPAL TUNNEL SYNDROME R/L

M62.838 ___SPASM OF MUSCLE_____ **M54.30** ___ SCIATICA Spr/Str

M79.7 ___ MYALGIA & MYOSITIS **M54.6** ___ PAIN IN THORACIC SPINE

R.51 ___ HEADACHES

Times Per Week:____for:___Weeks, OR: Times Per Month:____for Months

Patients to return or call, prior to renewal of prescriptions

PLAN OF CARE COMMENTS:_____
_____

PHYSICIAN'S
SIGNATURE:_____LICENSE:_____