Massage Therapy Prescription / Referral Form

FROM:
Doctor ____ Date __________________
Address ____
Phone ___________________ Fax __________________ Email ___________________

TO:
Caring Hands Therapeutic Massage (NPI: 1194360073)
207 Ridgely Avenue
Annapolis MD - 21401

Regarding Patient ____

TREATMENT IS MEDICALLY NECESSARY.
Please treat the patient for diagnoses listed below, using modalities / procedures marked below that are within your scope of practice.

Condition related to: _________________________

Date of Injury ___________________

Diagnosis Codes
354.0 ___ Carpal Tunnel Syndrome
723.1 ___ Cervicalgia
724.3 ___ Sciatica
784.0 ___ Headache
840.9 ___ Shoulders-Upper Arms Sprain / Strain
846.0 ___ Lumbosacral Sprain / Strain
847.0 ___ Cervical Sprain / Strain
847.1 ___ Thoracic Sprain / Strain
847.2 ___ Lumbar Sprain / Strain
Other: ____

Modalities/Procedures (CPT)

97010 Hot and Cold pack Therapy
97112 Neuromuscular Therapy
97124 Massage Therapy
97140 Manual Therapy

Duration and Frequency of Treatment

___ units, ___ time(s) per week for ___ weeks. OR ____________________________________

Treatment Goals
__ Decrease Pain
__ Decrease Inflammation ____
Decrease Muscle Tension / Spasms ____
Increase Mobility / Range of Motion ____

Other Instructions ____

Referring Physician Signature: ____ NPI: ______________