



Massage Therapy Prescription / Referral Form

FROM:

Doctor _____ Date _____

Address _____

Phone _____ Fax _____ Email _____

TO:

Caring Hands Therapeutic Massage (NPI: 1205441318)

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

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 _____

*every unit is a 15 minutes increment

Treatment Goals

___ Decrease Pain

___ Decrease Inflammation _____

Decrease Muscle Tension / Spasms _____

Increase Mobility / Range of Motion _____

Other Instructions _____

Referring Physician Signature: _____ NPI: _____