Massage Therapy Prescription/Referral Form

FROM: Doctor ___________________ Date _________
Address ______________________________________
Phone ________________ Fax _________________
Email ____________________

TO: Kimberly Andrade, LMT
425 SE Third Ave., Suite 209
Portland, OR 97214

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:
Auto Collision Date of Injury ________________

Diagnosis Codes
345.0 ___ 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)
97124 Massage Therapy
97140 Manual Therapy
97112 Neuromuscular Reeducation
97110 Therapeutic Exercises

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 ____

Kimberly Andrade, LMT #25184
www.thehorizonwellness.com