

# Massage Therapy Referral / Prescription / Treatment Plan

Please e-mail or mail to Jessica Gray, L.M. P., at [total.body@verizon.net](mailto:total.body@verizon.net), or 218 Main Street, P.M.B. #204, Kirkland, WA 98033-6108

From: Doctor \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Email \_\_\_\_\_

To: **Jessica Gray, L.M.P.** Phone: (425) 577-4269  
218 Main Street, P.M.B. #204 E-mail: [total.body@verizon.net](mailto:total.body@verizon.net)  
Kirkland, WA 98033-6108

Regarding Patient \_\_\_\_\_ D.O. B. \_\_\_\_\_

## TREATMENT IS MEDICALLY NECESSARY

Please treat the patient for diagnosis indicated below, using the modalities/ procedures check-marked below that are within your scope of practice.

### Modalities / Procedures

97124 \_\_\_ Massage Therapy

97140 \_\_\_ Manual Therapy Techniques

97010 \_\_\_ Hot or Cold Packs

### Condition is related to:

\_\_\_ Auto Accident Date of Injury \_\_\_\_\_

\_\_\_ Work Injury

\_\_\_ Illness

\_\_\_ Other \_\_\_\_\_

### Diagnosis Codes

354.0 \_\_\_ Carpal Tunnel Syndrome

723.1 \_\_\_ Cervicalgia

723.4 \_\_\_ Brachial Neuritis / Radiculitis (Upper Extremities)

724.3 \_\_\_ Sciatica

724.4 \_\_\_ Lumbosacral / Thoracic Neuritis Or Radiculitis (Lower Extremities)

729.1 \_\_\_ Fibromyalgia / Myalgia / Myositis

784.0 \_\_\_ Headache

840.9 \_\_\_ Shoulder-Upper Arms Sprains/Strains

846.0 \_\_\_ Lumbosacral Sprain / Strain

847.0 \_\_\_ Cervical Sprain / Strain

847.1 \_\_\_ Thoracic Sprain / Strain

847.2 \_\_\_ Lumber Sprain / Strain

847.3 \_\_\_ Sacral Sprain / Strain

847.4 \_\_\_ Coccyx Sprain / Strain

848.1 \_\_\_ T.M.J. Sprain / Strain

### Other Dx Codes

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

### Duration and Frequency of Treatment

\_\_\_ times per week for \_\_\_ weeks

OR \_\_\_ treatments

OR \_\_\_\_\_

### Treatment Goals

\_\_\_ Decrease Pain

\_\_\_ Decrease Inflammation

\_\_\_ Decrease Muscle Tension / Spasms

\_\_\_ Increase Mobility / Range of Motion

\_\_\_ Other \_\_\_\_\_

### Other Instructions

#### Provide

Self-Care Education

Exercise Education

Ergonomic Education

Yes

No

\_\_\_ \_\_\_

\_\_\_ \_\_\_

\_\_\_ \_\_\_

### Reporting

\_\_\_ Send Report \_\_\_ after 1<sup>st</sup> Visit \_\_\_ End of Rx.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

License # \_\_\_\_\_ NPI # \_\_\_\_\_