DOCTOR REFERRAL/PRESCRIPTION: FOR MEDICAL MASSAGE THERAPY

PATIENT'S NAME: _____ **DATE**: _____

PATIENT'S DATE OF BIRTH: _____

START DATE: _____ END DATE: _____

FREQUENCY: _____ TIMES PER WEEK

DOCTOR'S NAME(Please Print):_____

DOCTOR'S NPI: _____

DOCTOR'S PHONE: _____

DOCTOR'S ADDRESS: _____

DOCTOR'S SIGNATURE: _____

TREATMENT IS MEDICALLY NECESSARY. Please treat patient for diagnoses listed below, using the procedures within your scope of practice, unless otherwise noted.

DIAGNOSIS CODE: **_____TMJ(M26.639) ____CERVICALGIA(M54.2)**

_____MUSCLE SPASM(M62.40) _____THORACIC PAIN(M54.6)

_____LUMBAR PAIN(M54.50) _____SHOULDER PAIN(M25.519)

_____SACRAL PAIN(M53.3) _____LEG PAIN(M79.609)

_____SCIATICA UNSPECIFIED(M54.30)

OTHER DIAGNOSIS CODE W/DESCRIPTION:

_____

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