PRESCRIPTION / LETTER OF REFERRAL

"THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY"

DATE ________/________/_________

PATIENT ____

PHYSICIAN ________________________________ **ADDRESS** ____

PHONE ____________________________________ **FAX**: ____

REFERRED TO: Carole Suzanne Jackson, _BS, MA, LMT, CMMP, BCTMB; MA55130 **Phone**: 407-657-3755_

Any of the following Physicians' *Current Procedural Terminology,* CPT™ procedures and / or modalities, which are within this therapists' scope of practice training, & / or State & / or Patient's Insurance Policy regulations, may be used as therapist deems necessary during any treatment session. Normally four procedure units & 2 max modalities allowed per visit. A Unit = 15 - minutes. Conditions or prescription may require more units.

PROCEDURES and MODALITIES

- 97010 ☐ HOT/COLD PACKS (as necessary)
- 97014 ☐ ELECTRIC STIMULATION, un-attended
- 97018 ☐ PARAFFIN BATH
- 97022 ☐ WHIRLPOOL
- 97026 ☐ INFRA-RED
- 97032 ☐ ELECTRICAL STIMULATION, attended
- 97034 ☐ CONTRAST BATHS
- 97035 ☐ ULTRASOUND
- 97036 ☐ HYDROTHERAPY (full immersion)
- 97039 ☐ UNLISTED MODALITY, by report
- 97124 ☐ MASSAGE THERAPY
- 97139 ☐ UNLISTED PROCEDURE, by report
- 97140 ☒ MANUAL THERAPY TECHNIQUES
- 97799 ☐ Unlisted Physical Medicine Rehab …… Service or Procedure (By Report) (Initial or Re Assessment
- _____ ☐ OTHER ______________________________

PHYSICIAN'S ICD- 10 DIAGNOSIS OF PATIENT

- _______ ☐ MIGRAINES
- _______ ☐ HEADACHES
- _______ ☐ CERVICAL, Inc. Whiplash Injury Sprain / Strain
- _______ ☐ JAW (TMJ & Ligament) Sprain /Strain R ___ L____
- _______ ☐ CERVICALGIA (pain in neck)
- _______ ☐ INFRASPINATUS Sprain / Strain R_____L _____
- _______ ☐ SUBSCAPULARIS Sprain /Strain (muscle) R_ __ L______
- _______ ☐ SUPRASPINATUS Sprain/ Strain (muscle) R_ __ L______
- _______ ☐ SHOULDER & ARM (unspecified site) R ___ L_____
- _______ ☐ ELBOW & FOREARM (unspecified site) R ___ L_____
- _______ ☐ WRIST Sprain / Strain (unspecified site) R ___ L_____
- ______ ☐ CARPAL TUNNEL SYNDROME R ___ L _____
- _______ ☐ HAND Sprain / Strain (unspecified site) R ____ L _____
- _______ ☐ PAIN IN THORACIC SPINE
- ______ ☐ THORACIC (DORSAL) Sprain / Strain
- _______ ☐ LUMBAR Sprain / Strain
- _______ ☐ PELVIS (unspecified site) Sprain / Strain
- _______ ☐ HIP & THIGH (unspecified site)
- _______ ☐ SACROILIAC REGION (unspecified site) Spr/Str
- _______ ☐ SACRUM Sprain / Strain
- _______ ☐ LUMBOSACRAL RADICULITIS R _ L_
- _______ ☐ SCIATICA (neuralgia, neuritis) R _ L _
- _______ ☐ KNEE OR LEG Sprain/Strain R _ L _
- _______ ☐ ANKLE (unspecified site) Sprain/Strain R _ L _
- ______ _ ☐ FOOT (unspecified site) Sprain/Strain R _ L _
- _______ ☐ MYOFIBROSIS; muscles, ligament, fascia
- ______ _ ☐ SPASM OF MUSCLE___________________
- _______ ☐ MYALGIA & MYOSITIS (Fibromyositis)
- _______ ☐ Unspecified Disorder of Muscle, Ligament, Fascia
- _______ ☐ _______________________________________

Times Per Week: _______ for _____ Weeks, OR Times Per Month: _______ for __________Months, or Total Visits This Script __________

Patient to return or call, prior to renewal of prescription

PLAN OF CARE / COMMENTS:

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PHYSICIAN'S SIGNATURE: ____ **NPI #:** ___________________________________

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