MEDICAL MASSAGE PRESCRIPTION

"The following prescribed treatment is medically necessary."

Date: _____/_____/_____

Patient: _____

Physician: _____ Address: _____

Phone: _____ Fax: _____

Referred to: Oasis Massage, 292B Route 28, West Dennis Phone: 508-280-4242

Any of the following Physician's *Current Procedural Terminology*, CPT™ procedures and/or modalities, which are within this therapist's scope of practice, and training and/or State Licensing and/or Patient's Insurance Policy regulations, may be used as therapist deems necessary during any treatment session. Normally, 4 procedure units are allowed per visit and 2 modalities. A Unit = 15 minute segments of time. Conditions or prescription may require more units.

PROCEDURES and MODALITIES

97124 ☐Massage Therapy 97140 ☐Manual Therapy Techniques

PHYSICIAN'S DIAGNOSIS OF PATIENT

ICD-10	Description		ICD-10	Description	
_____	☐MIGRAINES		_____	☐LUMBAR Sprain/Strain	
_____	☐HEADACHES		_____	☐PELVIS (unspecified site) Sprain/Strain	
_____	☐CERVICAL, incl. Whiplash Injury Sprain/Strain		_____	☐HIP & THIGH (unspecified site)	
_____	☐JAW (TMJ & Ligament) Sprain/Strain	R__ L__	_____	☐SACROILIAC REGION (unspecified site)	
_____	☐CERVICALGIA (pain in neck)		_____	☐SACRUM Sprain/Strain	
_____	☐INFRASPINATUS Sprain/Strain	R__ L__	_____	☐LUMBOSACRAL RADICULITIS	R__ L__
_____	☐SUPRASPINATUS Sprain/Strain (muscle)	R__ L__	_____	☐SCIATICA (neuralgia, neuritis)	R__ L__
_____	☐SHOULDER & ARM (unspecified site)	R__ L__	_____	☐KNEE OR LEG Sprain/Strain	R__ L__
_____	☐ELBOW & FOREARM (unspecified site)	R__ L__	_____	☐ANKLE (unspecified site) Sprain/Strain	R__ L__
_____	☐WRIST Sprain/Strain (unspecified site)	R__ L__	_____	☐FOOT (unspecified site) Sprain/Strain	R__ L__
_____	☐CARPAL TUNNEL SYNDROME	R__ L__	_____	☐MYOFIBROSIS muscles, ligaments, fascia	
_____	☐HAND Sprain/Strain (unspecified site)	R__ L__	_____	☐SPASM OF MUSCLE _____	
_____	☐PAIN IN THORACIC SPINE		_____	☐MYALGIA & MYOSITIS (Fibromyositis)	
_____	☐THORACIC (DORSAL) Sprain/Strain		_____	☐Unspecified Muscle Disorder, Ligament, Fascia	
_____	☐Other: _____		_____	☐Other: _____	
_____	☐Other: _____		_____	☐Other: _____	
_____	☐Other: _____		_____	☐Other: _____	

PLAN OF CARE

Times per Week: _____ for ___ Weeks, OR Times per Month: _____ for ___Months, OR Total Visits: _____

I would like patient progress notes sent: ☐Weekly, ☐Monthly, ☐After all visits, ☐Other: _____

COMMENTS:_____

_____

_____

Patient to return or call, prior to renewal of this prescription.

Physician's Signature: _____

NPI#: _____ License #: _____