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

_____☐MIGRAINES

_____☐HEADACHES

_____☐CERVICAL, incl. Whiplash Injury Sprain/Strain

_____☐JAW (TMJ & Ligament) Sprain/Strain R__ L__

_____☐CERVICALGIA (pain in neck)

_____☐INFRASPINATUS Sprain/Strain 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)

_____☐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 msucles, ligaments, fascia

_____☐SPASM OF MUSCLE _____

_____☐MYALGIA & MYOSITIS (Fibromyositis)

_____☐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 This Script: _____

COMMENTS:_____

_____

_____

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

Physician's Signature: _____

NPI#: _____ License #: _____