

Referral for Massage Therapy

Date: ____/____/____

Patient Name: _____ DOB: _____

Physician: _____ Address: _____

Phone: _____ Fax: _____

Referred to: Oasis Massage, 292B Route 28, West Dennis **Phone:** 508-280-4242 **Fax:** 508-549-8109

Any **Current Procedural Terminology (CPT™) procedures** and modalities that fall within the therapist's **scope of practice, training, state licensing regulations, and the patient's insurance policy requirements** may be utilized at the therapist's discretion during a treatment session.

Standard guidelines typically allow for **four procedure units** and **two modalities** per visit. Each **unit** is defined as a **15-minute segment** of treatment time. However, certain conditions or prescriptions may necessitate additional units, which will be determined based on medical necessity and compliance with applicable regulations.

PHYSICIAN'S DIAGNOSIS OF PATIENT

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

"I certify that the care prescribed above is medically necessary"

Physician's Signature: _____

NPI#: _____

License #: _____