

MASSAGE THERAPY REFERRAL

Patient Name _____ Date of Injury _____

A. Diagnosis

- | | |
|---|--|
| <input type="checkbox"/> Headache 784.0 | <input type="checkbox"/> Muscle Spasm 728.85 |
| <input type="checkbox"/> Low Back Pain 724.2 | <input type="checkbox"/> Shoulder pain 719.41 |
| <input type="checkbox"/> Back Pain 724.5 | <input type="checkbox"/> Hip Pain 719.45 |
| <input type="checkbox"/> Neck Pain 723.1 | <input type="checkbox"/> Myofascial Pain/Myalgia 729.1 |
| <input type="checkbox"/> Thoracic Pain 724.1 | <input type="checkbox"/> Thoracic Outlet Syndrome 353.0 |
| <input type="checkbox"/> Cervical Sprain/Strain 847.0 | <input type="checkbox"/> Carpal Tunnel Syndrome 354 |
| <input type="checkbox"/> Thoracic Sprain/Strain 847.1 | <input type="checkbox"/> Neuralgia 729.2 |
| <input type="checkbox"/> Lumbar Sprain/Strain 847.2 | <input type="checkbox"/> Joint Swelling 719.0 |
| <input type="checkbox"/> Knee Sprain/Strain 844 | <input type="checkbox"/> Migraine 346 |
| <input type="checkbox"/> Ankle Sprain/Strain 845.00 | <input type="checkbox"/> Sinus Pain 473 |
| <input type="checkbox"/> Rotator Cuff Sprain/Strain 840.4 | <input type="checkbox"/> Sleep Disturbance 780.50 |
| <input type="checkbox"/> Shoulder Sprain/Strain 840.9 | <input type="checkbox"/> Frozen Shoulder 726.0 |
| <input type="checkbox"/> Elbow Sprain/Strain 841.0 | <input type="checkbox"/> Rotator Cuff Tear 726.1 |
| <input type="checkbox"/> Wrist Sprain/Strain 842.0 | <input type="checkbox"/> Torticollis 723.5 |
| <input type="checkbox"/> Hand Sprain/Strain 842.1 | <input type="checkbox"/> Sciatica 724.3 |
| <input type="checkbox"/> Lumbosacral Sprain/Strain 846 | <input type="checkbox"/> Late Effect Sprain/Strain (post 1yr.) 905.7 |
| <input type="checkbox"/> Sacroiliac Sprain/Strain 846.1 | <input type="checkbox"/> Other _____ |

Condition is related to:

MVA Work Injury Illness Other: _____

B. Medically Necessary Treatment: Implement Plan as Described Below

Duration and Frequency

_____ x per week for _____ weeks **or** _____ x per month for _____ months

Additional Instructions:

C. Referring Health Care Provider (HCP)

HCP Name _____

Address _____

Phone _____ Fax _____ Email _____

Reporting

Send Report after Initial Visit **or** Send Report at End of Prescription

Via:

Fax Mail Email: _____

HCP Signature: _____ Date: _____