Symmetry Massage and Fitness, LLC

Massage Therapy Referral/Prescription/Treatment Plan

From: (**Physician**'s name):_____ Email: _____
Date of Prescription: _____ Phone: _____ Fax: _____

To: **Jenny Baldwin**, ATC, LMP #MA00019126 * Phone: 360-609-4022 * Vancouver and Camas locations

Regarding **Patient**: _____ Phone:_____ ID# or DOB: _____

TREATMENT IS MEDICALLY NECESSARY. Please treat the patient for the diagnoses indicated below, using the procedures that are within your scope of practice, unless otherwise noted.

Diagnosis Codes:

One diagnosis code will allow for up to 30 minutes of treatment. Two or more codes involving both the trunk and extremities will allow for up to 60 minutes of treatment. All diagnosis codes provided must reflect soft tissue pathologies.

Trunk:	Extremities:
___784.0 Headache	___723.4 Upper: Brachial Neuritis/Radiculitis
___848.1 TMJ Sprain/Strain	___840.9 Shoulder and/or Upper Arm Sprain Strain
___723.1 Cervicalgia	___840.4 Rotator Cuff Sprain/Strain
___847.0 Cervical Sprain/Strain	___841.9 Elbow or Forearm Sprain/Strain
___847.1 Thoracic Sprain/Strain	___354.0 Carpal Tunnel Syndrome
___846.0 Lumbosacral Sprain/Strain	___729.5 Arm Pain
___847.3 Sacral Sprain/Strain	___843.9 Lower: Hip or Thigh Sprain/Strain
___847.4 Coccyx Sprain/Strain	___724.3 Sciatica
___724.5 Back Pain	___729.5 Leg Pain

Other diagnosis codes with descriptions:

_____

Condition Relating to

___auto accident ___work injury ___illness ___other _____

Procedures/Modalities:

____97010 Hot/Cold Packs
____97124 Massage (Effleurage, petrissage, tapotement)
____97140 Manual Therapy (includes but is not limited toTrigger Point Therapy and Myofascial Release)
There are precautions or contraindications for this patient regarding these procedures/modalities:

_____

_____

Duration and Frequency of Treatment

_____ **times** per week **for** _____ weeks **OR** _____ treatments

OR _____

Treatment Goals

_____ Decrease Pain
_____ Decrease Inflammation
_____ Decrease Muscle Tension / Spasms
_____ Increase Mobility / Range of Motion
_____ Other _____

Other Instructions

Reporting	**Reporting Method**
_____ Send Report after Initial Visit	_____ Fax
_____ Send Report at End of Rx	_____ Mail
_____ Other _____	

Physician's Signature _____ **Date** _____

License #_____**UPIN #** _____