Medical Massage Of Coweta
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Medical Massage Practitioner
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Physician's Prescription of Medical Necessity

Referring Physician:_____
Phone: _____ Fax: _____
Dr. License#: _____ Dr. NPI #_____
Dr. Address:
_____
Regarding Patient_____,
TREATMENT IS MEDICALLY NECESSARY. Please treat the patient for diagnosis indicated below, using the modalities/procedures check marked below that are within your scope of practice.

Modalities/Procedures
97124___Massage Therapy
97140___Manual Therapy Techniques
97010___Hot or Cold Packs
___Therapist's Discretion

Condition is related to:
____Auto Accident Date of Injury_____
____Work Injury
____Illness
____Other_____

Diagnosis Codes
354.0____ Carpal Tunnel Syndrome
723.1____ Cervicalgia
723.4____ Brachial Neuritis / Radiculitis (Upper Extremities)
724.3____ Sciatica
724.4____ Lumbosacral / Thoracic Neuritis Or Radiculitis (Lower Extremities)
729.1____ Fibromyalgia / Myalgia / Myositis
784.0____ Headache
840.9____ Shoulders-Upper Arms Sprain/Strain
846.0____ Lumbosacral Sprain / Strain
847.0____ Cervical Sprain / Strain
847.1____ Thoracic Sprain / Strain
847.2____ Lumbar Sprain / Strain
847.3____ Sacral Sprain / Strain
847.4____ Coccyx Sprain / Strain
848.1____ T.M.J Sprain / Strain

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

Provide	Yes	No
Self-Care Education	_____	_____
Exercise Education	_____	_____

Reporting Y / N _____ *Send Report* ____ *after 1st Visit* ____ *End of Rx*
Email report to: _____

Physician's Signature_____**Date**_____