

PHYSICIAN'S PRESCRIPTION / REFERRAL / MEDICAL NECESSITY

FROM DOCTOR: _____ DATE: ____ - ____ - 2008

PHONE: () _____ - _____ FAX: () _____ - _____

TO THERAPIST: Kirstin Davis PH: 503.504.2569 FAX: 5 04.469.0615
ADDRESS: 9925 SW Nimbus Ave, Suite 100, Beaverton Or 97008

REGARDING PATIENT _____, TREATMENT IS MEDICALLY NECESSARY. Please treat the patient for diagnoses indicated below, using the modalities/procedures checkmarked below that are within your scope of practice.

MODALITIES / PROCEDURES

- 97010___ HOT OR COLD PACKS
- 97039___ UNLISTED MODALITIES (SPECIFY)
- 97110___ THERAPEUTIC EXERCISE (R.O.M.)
- 97122___ MANUAL TRACTION
- 97124_X_ MASSAGE THERAPY
- 97139___ UNLISTED PROCEDURES (SPECIFY)
- 97140_X_ MANUAL THERAPY TECHNIQUES
- 97250___ MYOFASCIAL RELEASE
- 97530___ THERAPEUTIC ACTIVITY

DX CODES

- 354.0___ CARPAL TUNNEL SYNDROME
- 723.1___ CERVICALGIA
- 723.4___ UPPER EXTREMITIES: BRACHIAL NEURITIS / RADICULITIS
- 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

OTHER DX CODES

- 1. _____
- 2. _____
- 3. _____
- 4. _____

OF VISITS _____ # OF TIMES PER WEEK _____ # OF WEEKS _____

SPECIAL NOTES: _____

PHYSICIAN'S SIGNATURE _____
LICENSE# _____ UPIN# _____