CLINICAL MASSAGE THERAPY

Acute and Chronic Pain Management

Prescription

Patient Name: _____ Date: _____

Date of Injury: _____ ID#/DOB: _____

A. Referring Health Care Provider (HCP)

Contact Information

HCP Name/ID # _____

NPI#_____

Address _____

City _____ State_____ Zip_____

Phone _____

Fax _____

Email _____

Reporting - I will send an initial report after three first visits and a progress report after every 6-8 sessions. Please check how you would like to receive this information:

☐ Mail ☐ Email

☐ Send Copies of Chart Notes with each report.

B. Diagnosis (Include ICD-10 codes that specifically address Manual Therapy Treatment)

_____ ☐ Auto Accident ☐ Illness

_____ ☐ Work Injury ☐ Other _____

_____ _____

C. Medically Necessary Treatment: Implement Plan as Prescribed Below

Application (Primary and Secondary)

☐ Head_____

☐ Neck_____

☐ Chest_____

☐ Shoulders_____

☐ Abdomen_____

☐ Back_____

☐ Low back/Hips_____

☐ Upper extremities_____

☐ Lower extremities_____

☐ All of the above_____

☐ Other:_____

Treatment Type

☐ Manual Therapy_____

☐ Hot/Cold Packs_____

Frequency and Duration

☐ _____x a week for _____weeks

☐ _____x a month for _____months

Specific Instructions/Precautions:

Expiration Date:_____/_____/_____

_____

HPC Signature: _____ Date: _____

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