Theresa Stys, LMT
Licensed Massage Therapist
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# Massage Therapy Referral / Prescription / Treatment Plan

Dr._____ Date _____

Address_____

Phone _____ Fax _____ Email _____

License #_____ NPI # _____

RE: Patient _____

Diagnosis _____ ICD # _____

Diagnosis _____ ICD # _____

Diagnosis _____ ICD # _____

Condition is related to

_____ Auto Accident Date of injury _____ _____ Illness

_____ Work injury Date of injury_____ _____ Other _____

Treatment is medically necessary

Please treat the patient using the modalities/procedures check-marked below within the scope of your practice.

97124_____ Massage Therapy 97112 _____ Neuromuscular Re-education

97140_____ Manual Therapy / Lymphatic Massage / Myofascial Release

97010 _____ Modality hot or cold pack

_____ therapist's discretion _____ other_____

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_____

Reporting

___ Send report _____ after first visit ____End of treatment

Physician Signature_____ Date _____