

# PRESCRIPTION / LETTER OF REFERRAL

“ THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY ”

DATE: 07/01/2007

PATIENT: Ruth Wright

PHYSICIAN: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

REFERRED TO: CornerStone Massage Phone: 941-379-3632 Fax: 941-379-8089  
5550 Bee Ridge Rd Ste E 3 Sarasota Fl 34233

Any of the following Physicians' Current Procedural Terminology, CPT™ procedures and / or modalities, which are within this therapists' scope of practice, training, & / or State & / or Patient's Insurance Policy regulations, may be used as therapist deems necessary during any treatment session.  
Normally four units are allowed per visit. A Unit = 15 minute segments of time. Conditions or prescription may require more units.

## PROCEDURES and MODALITIES

- |  |   |
|--|---|
| 97010 <input type="checkbox"/> HOT/COLD PACKS (as necessary)     | 97036 <input type="checkbox"/> HYDROTHERAPY (full immersion)          |
| 97014 <input type="checkbox"/> ELECTRIC STIMULATION, un-attended | 97039 <input type="checkbox"/> UNLISTED MODALITY, by report           |
| 97018 <input type="checkbox"/> PARAFFIN BATH                     | 97124 <input type="checkbox"/> MASSAGE THERAPY                        |
| 97022 <input type="checkbox"/> WHIRLPOOL                         | 97139 <input type="checkbox"/> UNLISTED PROCEDURE, by report          |
| 97026 <input type="checkbox"/> INFRA-RED                         | 97140 <input type="checkbox"/> MANUAL THERAPY TECHNIQUES              |
| 97032 <input type="checkbox"/> ELECTRICAL STIMULATION, attended  | 97799 <input type="checkbox"/> Unlisted Physical Medicine Rehab ..... |
| 97034 <input type="checkbox"/> CONTRAST BATHS                    | Service or Procedure (By Report)                                      |
| 97035 <input type="checkbox"/> ULTRASOUND                        | _____ <input type="checkbox"/> OTHER _____                            |

## PHYSICIAN'S DIAGNOSIS OF PATIENT

- |  |  |
|--|--|
| 346. <input type="checkbox"/> MIGRAINES  | 847.2 <input type="checkbox"/> LUMBAR Sprain / Strain                            |
| 784.0 <input type="checkbox"/> HEADACHES   | 848.9 <input type="checkbox"/> PELVIS (unspecified site) Sprain / Strain         |
| 847.0 <input type="checkbox"/> CERVICAL, Inc. Whiplash Injury Sprain / Strain      | 843.9 <input type="checkbox"/> HIP & THIGH (unspecified site)                    |
| 848.1 <input type="checkbox"/> JAW (TMJ & Ligament) Sprain /Strain R __ L __       | 846.9 <input type="checkbox"/> SACROILLAC REGION (unspecified site) Spr/Str      |
| 723.1 <input type="checkbox"/> CERVICALGIA (pain in neck)                          | 847.3 <input type="checkbox"/> SACRUM Sprain / Strain                            |
| 840.3 <input type="checkbox"/> INFRASPINATUS Sprain / Strain R __ L __             | 724.4 <input type="checkbox"/> LUMBOSACRAL RADICULITIS R __ L __                 |
| 840.5 <input type="checkbox"/> SUBSCAPULARIS Sprain /Strain (muscle) R __ L __     | 724.3 <input type="checkbox"/> SCIATICA (neuralgia, neuritis) R __ L __          |
| 840.6 <input type="checkbox"/> SUPRASPINATUS Sprain/ Strain (muscle) R __ L __     | 844.9 <input type="checkbox"/> KNEE OR LEG Sprain/Strain R __ L __               |
| 840.9 <input type="checkbox"/> SHOULDER & ARM (unspecified site) R __ L __         | 845.00 <input type="checkbox"/> ANKLE (unspecified site) Sprain/Strain R __ L __ |
| 841.9 <input type="checkbox"/> ELBOW & FOREARM (unspecified site) R __ L __        | 845.10 <input type="checkbox"/> FOOT (unspecified site) Sprain/Strain R __ L __  |
| 842.00 <input type="checkbox"/> WRIST Sprain / Strain (unspecified site) R __ L __ | 728.2 <input type="checkbox"/> MYOFIBROSIS; muscles, ligament, fascia            |
| 354.0 <input type="checkbox"/> CARPAL TUNNEL SYNDROME R __ L __                    | 728.85 <input type="checkbox"/> SPASM OF MUSCLE _____                            |
| 842.10 <input type="checkbox"/> HAND Sprain / Strain (unspecified site) R __ L __  | 729.1 <input type="checkbox"/> MYALGIA & MYOSITIS (Fibromyositis)                |
| 724.1 <input type="checkbox"/> PAIN IN THORACIC SPINE                              | 728.9 <input type="checkbox"/> Unspecified Disorder Of Muscle, Ligament, Fascia  |
| 847.1 <input type="checkbox"/> THORACIC (DORSAL) Sprain / Strain                   | Other <input type="checkbox"/> _____   |

Times Per Week: \_\_\_\_\_ for \_\_\_\_\_ Weeks, OR Times Per Month: \_\_\_\_\_ for \_\_\_\_\_ Months, or Total Visits This Script \_\_\_\_\_

Patient to return or call, prior to renewal of prescription

## PLAN OF CARE / COMMENTS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ LICENSE: \_\_\_\_\_