# Massage Therapy Prescription / Referral Form

FROM: Doctor ___________________________________ Date _________________
Address ______________________________________________________________
Phone __________________ Fax _________________ Email __________________

TO: Barrie Robbins Bodywork, LMT
2360 NW Summerhill Dr.
Bend, OR 97001

Regarding Patient ______________________________________________________

**TREATMENT IS MEDICALLY NECESSARY.**
**Please treat the patient for diagnoses listed below, using modalities / procedures marked below that are within your scope of practice.**

**Condition related to:**
Auto Collision Date of Injury __________________

**Diagnosis Codes**
354.0 ___ Carpal Tunnel Syndrome
723.1 ___ Cervicalgia
724.3 ___ Sciatica
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
Other: ____________________

**Modalities/Procedures (CPT)**
97124 Massage Therapy
97140 Manual Therapy
97112 Neuromuscular Reeducation
97110 Therapeutic Exercises

**Duration and Frequency of Treatment**
___ units, ___ time(s) per week for ___ weeks. OR ____________________________________

**Treatment Goals**
__ Decrease Pain
__ Decrease Inflammation ____________________________________________________
__ Decrease Muscle Tension / Spasms __________________________________________
__ Increase Mobility / Range of Motion _________________________________________
Other Instructions____________________________________________________________


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