prescription referral form

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FROM: Doctor _____ Date _____
Address _____
Phone _____ Fax _____ Email _____
TO: Emily Harwood, LMT 506 SW 6th Avenue, Suite 602 Portland, OR 97204
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.

Modalities / Procedures
97124 __ Massage Therapy
97140 __ Manual Therapy Techniques
97010 __ Hot or Cold Packs
__ Practitioner's Discretion

Condition related to:
__ Auto Collision Date of Injury _____
__ Work Injury
__ Illness
__ Other _____

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 Diagnosis Codes
1 _____
2 _____
3 _____
4 _____
5 _____

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 _____

Other Instructions
_____
_____
_____
_____

Physician's Signature _____ Date _____

NPI # _____