

PRESCRIPTION / LETTER OF REFERRAL

"THE FOLLOWING PRESCRIBED MANUAL/MASSAGE THERAPY TREATMENT IS MEDICALLY NECESSARY"

PATIENT: _____ **DATE:** _____

PHYSICIAN: _____ **ADDRESS:** _____

PHONE: _____ **FAX:** _____

REFERRED TO: **SOMATIC WELLNESS MASSAGE THERAPY** **PHONE:** **304-288-8767**
THERAPISTS **LOIS FOSTER AND/OR MIKE FOSTER** **LOCATIONS:** **2831 WHITEHALL BLVD.**
WHITEHALL, WV 26554

PHYSICIAN'S DIAGNOSIS OF PATIENT

- | | | |
|---|---------|---|
| 346. <input type="checkbox"/> MIGRAINES | | 847.2 <input type="checkbox"/> LUMBAR Sprain / Strain |
| 307.8 <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 | R__ L__ | 843.9 <input type="checkbox"/> HIP & THIGH (unspecified site) |
| 848.1 <input type="checkbox"/> JAW (TMJ & Ligament) Sprain /Strain | | 846.9 <input type="checkbox"/> SACROILIAC 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_ |
| 840.5 <input type="checkbox"/> SUBSCAPULARIS Sprain /Strain (muscle) | R__ L__ | 724.3 <input type="checkbox"/> SCIATICA (neuralgia, neuritis) |
| 840.6 <input type="checkbox"/> SUPRASPINATUS Sprain/ Strain (muscle) | R__ L__ | 844.9 <input type="checkbox"/> KNEE OR LEG Sprain/Strain |
| 840.9 <input type="checkbox"/> SHOULDER & ARM (unspecified site) | R__ L__ | 845.00 <input type="checkbox"/> ANKLE (unspecified site) Sprain/Strain |
| 726.0 <input type="checkbox"/> FROZEN SHOULDER | R__ L__ | 845.10 <input type="checkbox"/> FOOT (unspecified site) Sprain/Strain |
| 841.9 <input type="checkbox"/> ELBOW & FOREARM (unspecified site) | R__ L__ | 728.2 <input type="checkbox"/> MYOFIBROSIS; muscles, ligament, fascia |
| 726.0 <input type="checkbox"/> TENNIS ELBOW | R__ L__ | 728.85 <input type="checkbox"/> SPASM OF MUSCLE_____ |
| 842.0 <input type="checkbox"/> WRIST Sprain / Strain (unspecified site) | R__ L__ | 729.1 <input type="checkbox"/> MYALGIA & MYOSITIS (Fibromyositis) |
| 354.0 <input type="checkbox"/> CARPAL TUNNEL SYNDROME | R__ L__ | 728.9 <input type="checkbox"/> Unspecified Disorder Of Muscle, Ligament, Fascia |
| 842.1 <input type="checkbox"/> HAND Sprain / Strain (unspecified site) | R__ L__ | 847.2 <input type="checkbox"/> LUMBAR Sprain / Strain |
| 724.1 <input type="checkbox"/> PAIN IN THORACIC SPINE | | 848.9 <input type="checkbox"/> PELVIS (unspecified site) Sprain / Strain |
| 847.1 <input type="checkbox"/> THORACIC (DORSAL) Sprain / Strain | | 843.9 <input type="checkbox"/> HIP & THIGH (unspecified site) |

TREATMENT GOALS

DECREASE PAIN DECREASE MUSCLE TENSION/SPASMS INCREASE MOBILITY

TIMES PER WEEK _____ FOR _____ WEEKS OR TIMES PER MONTH _____ FOR _____ MONTHS OR TOTAL VISITS THIS SCRIPT _____

PHYSICIAN'S SIGNATURE _____