



Medical Massage & Manual Therapy Referral

Patient: _____ DOB: _____
 Phone: _____ Insurance Carrier / ID #: _____

Procedures and Modalities

Massage & Manual Therapy: 97124 / 97140 Hot / Cold Pack: 97010 Taping: A4452

Condition to be Treated

<u>Cervical</u>	<u>Joint Pain</u>	<u>Other</u>		
<input type="checkbox"/> M43.6- Torticollis <input type="checkbox"/> M53.0- Cervicocranial Syndrome <input type="checkbox"/> M54.2- Cervicalgia <input type="checkbox"/> S13.4xxA- Cervical Ligament Sprain <th align="center"><u>Thoracic</u></th> <td> <input type="checkbox"/> M25.511- Shoulder Pain, RT <input type="checkbox"/> M25.512- Shoulder Pain, LT <input type="checkbox"/> M25.521- Elbow Pain, RT <input type="checkbox"/> M25.522- Elbow Pain, LT <input type="checkbox"/> M25.531-Wrist Pain, RT <input type="checkbox"/> M25.532-Wrist Pain, LT <input type="checkbox"/> M25.551- Hip pain, RT <input type="checkbox"/> M25.552- Hip pain, LT <input type="checkbox"/> M25.561- Knee Pain, RT <input type="checkbox"/> M25.562- Knee Pain, LT <th align="center"><u>Jaw</u></th> <td> <input type="checkbox"/> M77.11- Lateral Epicondylitis RT <input type="checkbox"/> M77.12- Lateral Epicondylitis LT <input type="checkbox"/> G56.01- Carpal Tunnel RT <input type="checkbox"/> G56.02- Carpal Tunnel LT <input type="checkbox"/> M62.830- Muscle Spasm, Back <input type="checkbox"/> M62.838- Muscle Spasm, Calf <input type="checkbox"/> M79.1- Myalgia, Unspecified site <input type="checkbox"/> M79.7- Fibromyalgia <input type="checkbox"/> R51- Headache <input type="checkbox"/> G43.909- Migraine NOS _____ _____ _____ _____ _____ _____ _____ _____ </td> </td>	<u>Thoracic</u>	<input type="checkbox"/> M25.511- Shoulder Pain, RT <input type="checkbox"/> M25.512- Shoulder Pain, LT <input type="checkbox"/> M25.521- Elbow Pain, RT <input type="checkbox"/> M25.522- Elbow Pain, LT <input type="checkbox"/> M25.531-Wrist Pain, RT <input type="checkbox"/> M25.532-Wrist Pain, LT <input type="checkbox"/> M25.551- Hip pain, RT <input type="checkbox"/> M25.552- Hip pain, LT <input type="checkbox"/> M25.561- Knee Pain, RT <input type="checkbox"/> M25.562- Knee Pain, LT <th align="center"><u>Jaw</u></th> <td> <input type="checkbox"/> M77.11- Lateral Epicondylitis RT <input type="checkbox"/> M77.12- Lateral Epicondylitis LT <input type="checkbox"/> G56.01- Carpal Tunnel RT <input type="checkbox"/> G56.02- Carpal Tunnel LT <input type="checkbox"/> M62.830- Muscle Spasm, Back <input type="checkbox"/> M62.838- Muscle Spasm, Calf <input type="checkbox"/> M79.1- Myalgia, Unspecified site <input type="checkbox"/> M79.7- Fibromyalgia <input type="checkbox"/> R51- Headache <input type="checkbox"/> G43.909- Migraine NOS _____ _____ _____ _____ _____ _____ _____ _____ </td>	<u>Jaw</u>	<input type="checkbox"/> M77.11- Lateral Epicondylitis RT <input type="checkbox"/> M77.12- Lateral Epicondylitis LT <input type="checkbox"/> G56.01- Carpal Tunnel RT <input type="checkbox"/> G56.02- Carpal Tunnel LT <input type="checkbox"/> M62.830- Muscle Spasm, Back <input type="checkbox"/> M62.838- Muscle Spasm, Calf <input type="checkbox"/> M79.1- Myalgia, Unspecified site <input type="checkbox"/> M79.7- Fibromyalgia <input type="checkbox"/> R51- Headache <input type="checkbox"/> G43.909- Migraine NOS _____ _____ _____ _____ _____ _____ _____ _____
<th align="center"><u>Lumbar & Sacrum/Coccyx</u></th> <td> <input type="checkbox"/> R68.84- Jaw Pain <input type="checkbox"/> M26.61- Adhesions of Temporomandibular Joint <input type="checkbox"/> M26.62- Pain in Temporomandibular Joint <input type="checkbox"/> M79.11 Myalgia of Mastication Muscle <input type="checkbox"/> S03.4xxA- Jaw Sprain </td> <td></td>	<u>Lumbar & Sacrum/Coccyx</u>	<input type="checkbox"/> R68.84- Jaw Pain <input type="checkbox"/> M26.61- Adhesions of Temporomandibular Joint <input type="checkbox"/> M26.62- Pain in Temporomandibular Joint <input type="checkbox"/> M79.11 Myalgia of Mastication Muscle <input type="checkbox"/> S03.4xxA- Jaw Sprain		
<input type="checkbox"/> M48.061- Lumbar Spinal Stenosis <input type="checkbox"/> M54.5- Lumbago <input type="checkbox"/> M54.41- Lumbago, RT Sciatica <input type="checkbox"/> M54.42- Lumbago, LT Sciatica <input type="checkbox"/> S33.5xxA- Lumbar Ligament Sprain <input type="checkbox"/> R10.2- Pelvic/Perineal Pain <input type="checkbox"/> M53.3- Sacroiliac Pain <input type="checkbox"/> S33.8xxA- Sacrum/Coccyx Ligament sprain				

Duration and Frequency

_____ Times per Week for _____ Weeks **OR** _____ Times per Month for _____ Months
 Other: _____ *Please write script for no more than 3 month increments*

Short/Long Term Treatment Goals

Referring Provider: _____ Phone/Fax#: _____

Provider Signature: _____ Date: _____