# MASSAGE THERAPY REFERRAL / PRESCRIPTION / TREATMENT PLAN

From: Doctor _____ Date: _____
Address: _____ Phone: _____
Fax: _____
To: Silver Liner Mobile Massage Studio
Massage Therapist : Danielle Rothenbuehler #2363
Orange County & Inland Empire Area

Silver-Liner.com
Phone: 949-606-4081
info@silver-liner.com

Regarding Patient: _____

Treatment is medically necessary: Please treat the patient for diagnoses indicated below, using the modalities / procedures check marked below that are within your scope of practice.
Physicians Signature _____ Date: _____
License # _____ UPIN# _____

Modalities / Procedures
97124 _____ Massage Therapy
97140 _____ Manual Therapy Techniques
97010 _____ Hot or Cold Packs

Condition is related to:
_____ Auto Accident _____ Other _____
_____ Work Injury _____
_____ Illness _____

Diagnosis Codes
345.0 _____ Carpel Tunnel Syndrome
723.1 _____ Cervicalgia
723.4 _____ Brachial Neuritis / Radiculitis (upper extremities)
724.3 _____ Sciatica
724.4 _____ Lumbosacral /Thoracic Neuritis or Radiculitis (lower extremities)
724.5 _____ Back Pain
728.85 _____ Myospasm
729.1 _____ Fibromyalgia / Myalgia / Myositis
729.5 _____ Arm or Leg Pain
784.0 _____ Headache
839.01 _____ Subluxation cervical vertebrae
839.21 _____ subluxation thoracic vertebrae
839.20 _____ subluxation lumbar vertebrae
839.42 _____ subluxation sacral region
840 9 _____ Shoulders - Upper Arms Sprain / Strain
841.9 _____ elbow or forearm sprain / strain
843.9 _____ Hip or Thigh Sprain / Strain
846.0 _____ Lumbosacral Sprain / Strain
847.0 _____ Cervical Sprain / Strain
847.1 _____ Thoracic Sprain / Strain
847.2 _____ Lumbar Sprain / Strain
847.3 _____ Sacral Sprain / Strain
847.4 _____ Coccyx Sprain / Strain
848.1 _____ T.M.J. Sprain / Strain

Other Codes: See below:

Duration and Frequency of Treatment

_____ Times Per Week For _____ Weeks
_____ 60 minutes _____ 90 minutes
OR _____ Treatments
OR _____
In-Home Service Studio location

_____ Decrease Pain
_____ Decrease Inflammation
_____ Decrease Muscle Tension / Spasms
_____ Increase Mobility / Range of Motion
_____ Other _____

Other Diagnosis Codes:
1. _____
2. _____
3. _____

Treatment Goals