Physician Referral/Prescription: Medical Necessity for Massage and Manual Therapy

DATE: _____/_____/_____

PATIENT: _____**PHONE:**_____**DOI:** _____

REFERRING PHYSICIAN: _____**ADDRESS:** _____

PHONE: _____**FAX**_____ **NPI**: _____

REFERRED TO: **BEAU MIAKINKOFF, LMT OR Lic#12878 Phone: 541-863-9523**
850 Cook Street
Myrtle Creek, OR 97457

PHYSICIAN'S DIAGNOSIS OF PATIENT

1. _____._____ 2. _____._____ 3. _____._____ 4. _____._____

Evaluation and Treatment Plan:

Please evaluate (97750) and treat patient using procedures and modalities which are within the scope of practice for a Licensed Massage Therapist in Oregon, including but not limited to the following list of procedures and modalities. The use of each procedure for each treatment shall be determined by the diagnosis, patient's presenting complaints/symptoms, range of motion considerations, and patient tolerance.

If symptoms of myofascial pain syndrome are detected during evaluation or treatment (the presence of trigger points located along taut/tender bands within the muscle fiber) please check global posture and gait for possible remote and local perpetuating factors and treat to correct them.

Procedures and Modalities:

97010 HOT/COLD PACKS (as necessary)
97032 ELECTRICAL STIMULATION (manual)
97110 THERAPEUTIC EXERCISE
97112 NEUROMUSCULAR RE-EDUCATION
97124 MASSAGE THERAPY
97140 MANUAL THERAPY TECHNIQUES
97530 THERAPEUTIC ACTIVITES
97140 CRANIALSACRAL THERAPY

☐ There are precautions or contraindications for this patient: _____
☐ Please do not instruct patient regarding self-stretches.
☐ Please do not instruct patient to increase water inake followeing treatment.

Prescription:

Number of sessions per week:_____ **Total number of sessions:**_____ ☐ **PRN**
(treatment is prescribed for 2 hour sessions)

Patient to return or call, prior to renewal of prescription

PHYSICIAN'S SIGNATURE: _____**Date**_____