

# Massage Therapy Referral / Prescription / Treatment Plan

Please fax to Larry Swanson, LMP, at 206-260-9081

FROM: Doctor \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Other \_\_\_\_\_

To: **Larry Swanson, LMP** Fax: **206-260-9081**  
509 Olive Way, Suite 652 Phone: 206-624-6255  
Seattle, WA 98101

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.

### Modalities/Procedures

97124 \_\_\_\_\_ Massage Therapy  
97140 \_\_\_\_\_ Manual Therapy Techniques  
97010 \_\_\_\_\_ Hot or Cold Packs  
\_\_\_\_\_ therapist's discretion

### Condition is related to:

\_\_\_\_\_ Auto Accident Date of Injury \_\_\_\_\_  
\_\_\_\_\_ Work Injury  
\_\_\_\_\_ Illness  
\_\_\_\_\_ Other \_\_\_\_\_

### Diagnosis Codes

354.0 \_\_\_\_\_ Carpal Tunnel Syndrome  
723.1 \_\_\_\_\_ Cervicalgia  
723.4 \_\_\_\_\_ Brachial Neuritis / Radiculitis (Upper Extremities)  
724.3 \_\_\_\_\_ Sciatica  
724.4 \_\_\_\_\_ Lumbosacral / Thoracic Neuritis Or Radiculitis (Lower Extremities)  
729.1 \_\_\_\_\_ Fibromyalgia / Myalgia / Myositis  
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  
847.3 \_\_\_\_\_ Sacral Sprain / Strain  
847.4 \_\_\_\_\_ Coccyx Sprain / Strain  
848.1 \_\_\_\_\_ T.M.J. Sprain / Strain

#### Other Dx Codes

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_  
5. \_\_\_\_\_

### Duration and Frequency of Treatment

\_\_\_\_\_ times per week for \_\_\_\_\_ weeks

OR \_\_\_\_\_ treatments

OR \_\_\_\_\_

### Treatment Goals

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

### Other Instructions

Provide	Yes	No
Self-Care Education	_____	_____
Exercise Education	_____	_____
Ergonomic Education	_____	_____

### Reporting

\_\_\_\_\_ Send Report \_\_\_\_\_ after 1<sup>st</sup> Visit \_\_\_\_\_ End of Rx Fax report to: \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

License # \_\_\_\_\_ NPI # \_\_\_\_\_