

PRESCRIPTION / LETTER OF REFERRAL

"THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY"

DATE _____/_____/_____

PATIENT: _____

PHYSICIAN: _____ **ADDRESS:** _____

PHONE: _____ **FAX:** _____

REFERRED TO: Alexis Kurtzman LMP NKT AMMP **Phone:** 206-946-2040

Any of the following Physicians' *Current Procedural Terminology, CPT™* procedures and / or modalities, which are within this therapists' scope of practice, and training, and / or State Licensing and / or Patient's Insurance Policy regulations, may be used as therapist deems necessary during any treatment session. Normally 4 procedure units are allowed per visit and 2 modalities. A Unit = 15 minute segments of time. Conditions or prescription may require more units.

PROCEDURES and MODALITIES

- | | | | | | |
|-------|--------------------------|----------------------------------|-------|--------------------------|---|
| 97010 | <input type="checkbox"/> | HOT/COLD PACKS (as necessary) | 97122 | <input type="checkbox"/> | NEUROMUSCULAR |
| 97016 | <input type="checkbox"/> | CUPPING THERAPY | 97122 | <input type="checkbox"/> | NMT RE-EDUCATION |
| 97018 | <input type="checkbox"/> | PARAFFIN BATH | 97124 | <input type="checkbox"/> | MASSAGE THERAPY |
| 97026 | <input type="checkbox"/> | INFRA-RED | 97140 | <input type="checkbox"/> | MANUAL THERAPY TECHNIQUES |
| 97032 | <input type="checkbox"/> | ELECTRICAL STIMULATION, attended | 97749 | <input type="checkbox"/> | Initial Assessment/Evaluation |
| 97034 | <input type="checkbox"/> | CONTRAST BATHS | 97799 | <input type="checkbox"/> | Unlisted Physical Medicine Rehab Service or Procedure ie: Laser Therapy (By Report) |
| 97035 | <input type="checkbox"/> | ULTRASOUND | | | |

PHYSICIAN'S DIAGNOSIS OF PATIENT (Please fill in the ICD-10 Codes)

ICD-10	Description		ICD-10	Description	
_____	<input type="checkbox"/> MIGRAINES		_____	<input type="checkbox"/> LUMBAR Sprain / Strain	
_____	<input type="checkbox"/> HEADACHES		_____	<input type="checkbox"/> PELVIS (unspecified site) Sprain / Strain	
_____	<input type="checkbox"/> CERVICAL, Inc. Whiplash Injury Sprain / Strain		_____	<input type="checkbox"/> HIP & THIGH (unspecified site)	
_____	<input type="checkbox"/> JAW TM } & Ligament) Sprain/Strain	R L	_____	<input type="checkbox"/> SACROILIAC REGION (unspecified site)	
_____	<input type="checkbox"/> CERVICALGIA (pain in neck)		_____	<input type="checkbox"/> SACRUM Sprain / Strain	
_____	<input type="checkbox"/> INFRASPINATUS Sprain / Strain	R L	_____	<input type="checkbox"/> LUMBOSACRAL RADICULITIS	R L
_____	<input type="checkbox"/> SUPRASPINATUS Sprain/ Strain (muscle)	R L	_____	<input type="checkbox"/> SCIATICA (neuralgia, neuritis)	R L
_____	<input type="checkbox"/> SHOULDER & ARM (unspecified site)	R L	_____	<input type="checkbox"/> KNEE OR LEG Sprain/Strain	R L
_____	<input type="checkbox"/> ELBOW & FOREARM (unspecified site)	R L	_____	<input type="checkbox"/> ANKLE (unspecified site) Sprain/Strain	R L
_____	<input type="checkbox"/> WRIST Sprain / Strain (unspecified site)	R L	_____	<input type="checkbox"/> FOOT (unspecified site) Sprain/Strain	R L
_____	<input type="checkbox"/> CARPAL TUNNEL SYNDROME	R L	_____	<input type="checkbox"/> MYOFIBROSIS muscles, ligament, fascia	
_____	<input type="checkbox"/> HAND Sprain / Strain (unspecified site)	R L	_____	<input type="checkbox"/> SPASM OF MUSCLE	
_____	<input type="checkbox"/> PAIN IN THORACIC SPINE		_____	<input type="checkbox"/> MYALGIA & MYOSITIS (Fibromyositis)	
_____	<input type="checkbox"/> THORACIC (DORSAL) Sprain / Strain		_____	<input type="checkbox"/> Unspecified Muscle Disorder, Ligament, Fascia	

Other _____

Other _____

Other _____

Other _____

Other _____

Other _____

Times Per Week: _____ **for** _____ **Weeks, OR Times Per Month:** _____ **for** _____ **Months, or Total Visits This Script** _____

Patient to return or call, prior to renewal of prescription

PLAN OF CARE / COMMENTS:

PHYSICIAN'S SIGNATURE: _____ **NPI #:** _____