Massage Therapy Prescription /Referral Form

FROM: Doctor _____ Date _____

Address _____

Phone _____ Fax _____ Email _____

To: Crystal McCray, LMT – Cincinnati Muscle Therapy LLC
6204 Hamilton Ave. Suite 6D
Cincinnati, OH 45224

Regarding Patient _____ Date of Birth _____

TREATMENT IS MEDICALLY NECESSARY.
Please treat the patient for diagnoses listed below, using modalities / procedures marked below that are within your scope of practice.

Condition related to:
Auto Collision Date of Injury _____

Diagnosis Codes

354.0 ____ Carpal Tunnel Syndrome
723.1 ____ Cervicalgia
724.3 ____ Sciatica
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
Other: _____

Modalities/Procedures (CPT)

_____ 97124 Massage Therapy
_____ 97140 Manual Therapy
_____ 97112 Neuromuscular Reeducation
_____ 97110 Therapeutic Exercises

Duration and Frequency of Treatment

____ units, _____ times(s) per week for ____ weeks. OR _____

Treatment Goals

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

Other Instructions: _____

Crystal McCray, LMT
Cincinnati Muscle Therapy LLC
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