Please treat my patient, _____, for the diagnoses indicated below using the modalities or procedures prescribed that are within your scope of practice.

MODALITIES / PROCEDURES

97140 ___ Manual Therapy, Lymphatic Drainage, Myofascial release
97810 ___ Acupuncture
___ Magnesium Sulfate Float Therapy
97124 ___ Massage Therapy
97010 ___ Hot or Cold Packs

DX CODES

354.0 ___ Carpal Tunnel Syndrome
723.1 ___ Cervicalgia
723.4 ___ Upper Extremities: Brachial Neuritis / Radiculitis
724.3 ___ Sciatica
724.4 ___ Lumbosacral / Thoracic Neuritis or Radiculitis
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
848.1 ___ T.M.J. Sprain / Strain
457.1 ___ Lymphedema, Lymphangiectasis, Lymphatic obstruction, Lymphatic vessel obliteration
457.0 ___ Postmastectomy lymphedema syndrome
E812.0 ___ Collision with motor vehicle (driver)
E812.1 ___ Collision with motor vehicle (passenger)

Other pertinent DX codes:

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

Additional notes to Therapist _____

_____

Referred to:

A Healing Trail Wellness Center

500 Burlington Rd. Harwinton, CT. 860-485-0405

# of times per week _____ x # of weeks _____ = Number of total Visits _____

The above requested treatments are MEDICALLY NECESSARY for this patient.

Physician's Signature_____ CT License # _____

Physician's Name Printed _____ Date _____

Physician's Phone & address _____