HEALTH STUDIO

PRESCRIPTION / LETTER OF REFERRAL

"THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY"

DATE______/______/________

PATIENT: ____

PHYSICIAN:______________________________**ADDRESS:** ______________________________

PHONE:______________________________**FAX:** ______________________________

REFERRED TO: Health Studio, Leiah Carr, LMT MA 29890 MM 11872 **Phone:** 904-351-8012

Fax prescription/letter of referral to: 904-744-6108

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.

Code	☐	Procedure	Code	☐	Procedure
97010	☐	HOT/COLD PACKS (as necessary)	97039	☐	UNLISTED MODALITY, by report
97014	☐	ELECTRIC STIMULATION, un-attended	97036	☐	HYDROTHERAPY (full immersion)
97018	☐	PARAFFIN BATH	97124	☐	MASSAGE THERAPY
97022	☐	WHIRLPOOL	97139	☐	UNLISTED PROCEDURE, by report
97026	☐	INFRA-RED	97140	☐	MANUAL THERAPY TECHNIQUES
97032	☐	ELECTRICAL STIMULATION, attended	97749	☐	Initial Assessment /Evaluation
97034	☐	CONTRAST BATHS	97799	☐	Unlisted Physical Medicine Rehab Service or Procedure ie; Laser Therapy (By Report)
97035	☐	ULTRASOUND			

PROCEDURES and MODALITIES

PHYSICIAN'S DIAGNOSIS OF PATIENT

ICD-10	☐	Description			ICD-10	☐	Description		
________	☐	MIGRAINES			________	☐	LUMBAR Sprain / Strain		
________	☐	HEADACHES			________	☐	PELVIS (unspecified site) Sprain / Strain		
________	☐	CERVICAL, Inc. Whiplash Injury Sprain / Strain			________	☐	HIP & THIGH (unspecified site)		
________	☐	JAW (TMJ & Ligament) Sprain/Strain	R	L	________	☐	SACROILIAC REGION (unspecified site)		
________	☐	CERVICALGIA (pain in neck)			________	☐	SACRUM Sprain / Strain		
________	☐	INFRASPINATUS Sprain / Strain	R	L	________	☐	LUMBOSACRAL RADICULITIS	R	L
________	☐	SUPRASPINATUS Sprain/ Strain (muscle)	R	L	________	☐	SCIATICA (neuralgia, neuritis)	R	L
________	☐	SHOULDER & ARM (unspecified site)	R	L	________	☐	KNEE OR LEG Sprain/Strain	R	L
________	☐	ELBOW & FOREARM (unspecified site)	R	L	________	☐	ANKLE (unspecified site) Sprain/Strain	R	L
________	☐	WRIST Sprain / Strain (unspecified site)	R	L	________	☐	FOOT (unspecified site) Sprain/Strain	R	L
________	☐	CARPAL TUNNEL SYNDROME	R	L	________	☐	MYOFIBROSIS muscles, ligament, fascia		
________	☐	HAND Sprain / Strain (unspecified site)	R	L	________	☐	SPASM OF MUSCLE__________________		
________	☐	PAIN IN THORACIC SPINE			________	☐	MYALGIA & MYOSITIS (Fibromyositis)		
________	☐	THORACIC (DORSAL) Sprain / Strain			________	☐	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:

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PHYSICIAN'S SIGNATURE:______________________________**NPI #:** ______________________

By Vivian Madison Copyright 1989 © Revised 09/30/2015