PRESCRIPTION / LETTER OF REFERRAL

"THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY"

PATIENT: _____ PHYSICIAN: _____

PHYSICIAN ADDRESS: _____

PHONE:_____ FAX:_____

REFERRED TO: A Good Life Massage, LLC **PHONE:** 201-673-2295 **FAX:** 609-772-4893

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

PROCEDURES AND MODALITIES

97014	ELECTRIC STIMULATION, un-attended
97032	ELECTRICAL STIMULATION, attended
97035	ULTRASOUND
97124	MASSAGE THERAPY
97140	MANUAL THERAPY TECHNIQUES
97530	THERAPEUTIC ACTIVITIES, direct patient contact by provider, each 15 minutes

PHYSICIAN'S DIAGNOSIS OF PATIENT

ICD-10 CODE	DESCRIPTION
S46.901A	TENDONITIS
M79.672	PAIN IN LEFT FOOT
M79.671	PAIN IN RIGHT FOOT
M72.2	PLANTARFASCITIS
M62.831	CALF SPASMS
M54.5	LOWER BACK PAIN
M54.2	CERVICALGIA
M51.06	INTERVERTEBRAL DISC DISORDERS, LUMBER REGION
M54.3	SCIATICA
M53.82	NECK PAIN
M25.511	PAIN IN RIGHT SHOULDER
M25.512	PAIN IN LEFT SHOULDER
OTHER	

Times Per Week: _____ for_____Weeks, OR Times Per Month:_____ for _____ Months, OR Total Visits this Script _____

PLAN OF CARE/ COMMENTS

_____

_____

PHYSICIAN'S SIGNATURE: _____

PHYSICIAN'S NPI#: _____