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 PAC 006601810 Phone: 904-477-2277

Fax prescription/letter of referral to: 904-744-8038

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

97010 ☐ HOT/COLD PACKS (as necessary)
97014 ☐ ELECTRIC STIMULATION, un-attended
97018 ☐ PARAFFIN BATH
97022 ☐ WHIRLPOOL
97026 ☐ INFRA-RED
97032 ☐ ELECTRICAL STIMULATION, attended
97034 ☐ CONTRAST BATHS
97035 ☐ ULTRASOUND
97036 ☐ HYDROTHERAPY (full immersion)
97039 ☐ UNLISTED MODALITY, by report
97124 ☐ MASSAGE THERAPY
97139 ☐ UNLISTED PROCEDURE, by report
97140 ☐ MANUAL THERAPY TECHNIQUES
97799 ☐ Unlisted Physical Medicine Rehab ……
97112 ☐ Neuromuscular Re-education
_____ ☐ OTHER _____

PHYSICIAN'S DIAGNOSIS OF PATIENT

346.00. ☐ MIGRAINES
357.6 ☐ PERIPHERAL NEUROPAHTHY (PAC)
457.1 ☐ LYMPHEDEMA
784.0 ☐ HEADACHES
847.0 ☐ CERVICAL, Inc. Whiplash Injury Sprain / Strain
848.1 ☐ JAW (TMJ & Ligament) Sprain /Strain R __ L__
723.1 ☐ CERVICALGIA (pain in neck)
840.3 ☐ INFRASPINATUS Sprain / Strain R __ L __
840.5 ☐ SUBSCAPULARIS Sprain /Strain (muscle) R __ L __
840.6 ☐ SUPRASPINATUS Sprain/ Strain (muscle) R __ L __
840.9 ☐ SHOULDER & ARM (unspecified site) R __ L __
841.9 ☐ ELBOW & FOREARM (unspecified site) R __ L __
842.00 ☐ WRIST Sprain / Strain (unspecified site) R __ L __
354.0 ☐ CARPAL TUNNEL SYNDROME R __ L __
842.10 ☐ HAND Sprain / Strain (unspecified site) R __ L __
724.1 ☐ PAIN IN THORACIC SPINE
847.1 ☐ THORACIC (DORSAL) Sprain / Strain
847.2 ☐ LUMBAR Sprain / Strain
848.9 ☐ PELVIS (unspecified site) Sprain / Strain
843.9 ☐ HIP & THIGH (unspecified site)
846.9 ☐ SACROILIAC REGION (unspecified site) Spr/Str
847.3 ☐ SACRUM Sprain / Strain
724.4 ☐ LUMBOSACRAL RADICULITIS R _ L_
724.3 ☐ SCIATICA (neuralgia, neuritis) R _ L _
844.9 ☐ KNEE OR LEG Sprain/Strain R _ L _
845.00 ☐ ANKLE (unspecified site) Sprain/Strain R _ L _
845.10 ☐ FOOT (unspecified site) Sprain/Strain R _ L _
728.2 ☐ MYOFIBROSIS; muscles, ligament, fascia
728.85 ☐ SPASM OF MUSCLE_____
729.1 ☐ MYALGIA & MYOSITIS (Fibromyositis)
728.9 ☐ Unspecified Disorder Of Muscle, Ligament, Fascia
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:** _____