HEAD AND NECK PAIN RELIEF SPECIALIST
Headache | Migraine | Whiplash | Stress | Anxiety
8100 NE Parkway Drive, Suite 25, Vancouver WA 98662
Office: 360.524.3874 / Fax: 360.208.9475 / Relax@AvaniMassagePNW.com

PRESCRIPTION / LETTER OF REFERRAL

"THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY"

DATE ________/________/_________

PATIENT ____

PHYSICIAN ______________________ **ADDRESS** ______________________

PHONE ______________________ **FAX:** ______________________

REFERRED TO: Jessica S. King, LMT Phone: (360) 524-3874 Fax: (360) 208-9475

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 procedure units & 2 max modalities allowed per visit. A Unit = 15 - minutes. Conditions or prescription may require more units.

PROCEDURES and MODALITIES

X 97010 HOT/COLD PACKS (as necessary)
X 97124 MASSAGE THERAPY
X 97026 INFRARED

CONDITION RELATED TO:

___ AUTO ACCIDENT
___ WORK INJURY
___ SPORTS INJURY
___ OTHER: ______________________

PHYSICIAN'S ICD- 10 DIAGNOSIS OF PATIENT (LIST ALL THAT APPLY):

_______ MIGRAINES
_______ HEADACHES
_______ CERVICAL, Inc. Whiplash Injury Sprain / Strain
_______ JAW (TMJ & Ligament) Sprain /Strain R ___ L____
_______ CERVICALGIA (pain in neck)
_______ INFRASPINATUS Sprain / Strain R ___ L____
_______ SUBSCAPULARIS Sprain /Strain (muscle) R ___ L____
_______ SUPRASPINATUS Sprain/ Strain (muscle) R ___ L____
_______ SHOULDER & ARM (unspecified site) R ___ L____
_______ ELBOW & FOREARM (unspecified site) R ___ L____
_______ WRIST Sprain / Strain (unspecified site) R ___ L____
_______ CARPAL TUNNEL SYNDROME R ___ L____
_______ HAND Sprain / Strain (unspecified site) R ___ L____
_______ PAIN IN THORACIC SPINE
_______ THORACIC (DORSAL) Sprain / Strain

_______ LUMBAR Sprain / Strain
_______ PELVIS (unspecified site) Sprain / Strain
_______ HIP & THIGH (unspecified site)
_______ SACROILIAC REGION (unspecified site) Spr/Str
_______ SACRUM Sprain / Strain
_______ LUMBOSACRAL RADICULITIS R ___ L____
_______ SCIATICA (neuralgia, neuritis) R ___ L____
_______ KNEE OR LEG Sprain/Strain R ___ L____
_______ ANKLE (unspecified site) Sprain/Strain R ___ L____
_______ FOOT (unspecified site) Sprain/Strain R ___ L____
_______ MYOFIBROSIS; muscles, ligament, fascia
_______ SPASM OF MUSCLE____________________
_______ MYALGIA & MYOSITIS (Fibromyositis)
_______ Unspecified Disorder of Muscle, Ligament, Fascia
_______ ______________________________
_______ ______________________________

Patient to return or call, prior to renewal of prescription

Plan of Care:
3x Week for 2 Weeks / 2x Week for 2 Weeks / 1x Week for 2 Weeks OR Total Visits This Script 12 OR As directed in comments.

COMMENTS:

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