

Physician Referral/Prescription: Medical Necessity for Massage Therapy

From (Physician's name): _____

Date of Prescription: _____ Phone: _____ Fax: _____

To: Optima Clinic, LLC
3800 SW Cedar Hills Boulevard, Suite 203
Beaverton, OR 97005
503/526-0734

Patient: _____ Phone: _____ ID# or DOB: _____

TREATMENT IS MEDICALLY NECESSARY. Please treat the patient for the diagnoses indicated below, using the procedures that are within your scope of practice, unless otherwise noted.

Diagnosis Codes:

One diagnosis code will allow for up to 30 minutes of treatment. Two or more codes involving the trunk and extremities will allow for up to 60 minutes of treatment. All diagnosis codes provided must reflect soft tissue pathologies.

Trunk:

- 784.0 Headache
- 848.1 TMJ Sprain/Strain
- 723.1 Cervicalgia
- 847.0 Cervical Sprain/Strain
- 847.1 Thoracic Sprain/Strain
- 847.2 Lumbar Sprain/Strain
- 847.3 Sacral Sprain/Strain
- 847.4 Coccyx Sprain/Strain
- 724.5 Back Pain

Extremities:

- 723.4 Upper Extremities: Brachial Neuritis/Radiculitis
- 840.9 Shoulder and/or Upper Arm Sprain/Strain
- 840.4 Rotator Cuff Sprain/Strain
- 841.9 Elbow or Forearm Sprain/Strain
- 354.0 Carpal Tunnel Syndrome
- 729.5 Arm Pain
- 843.9 Hip or Thigh Sprain/Strain
- 724.3 Sciatica
- 729.5 Leg Pain

Other Diagnosis Codes with Descriptions: _____

Procedures/Modalities:

The procedures listed are within the scope of practice for a Licensed Massage Therapist in Oregon. The use of each procedure for each session will be determined by the diagnosis, patient's presenting complaints/symptoms and patient tolerance.

97001, 97002 Evaluation and Re-Evaluation

97110 Therapeutic Exercise (Assisted Stretching)

97010 Hot/Cold Packs or Topical Preparations

97140 Manual Therapy (includes, but is not limited to:

97124 Massage (effleurage, petrissage and tapotement)

Trigger Point Therapy and Myofascial Release)

There are precautions or contraindications for this patient regarding these procedures/modalities: _____

Please do Please do not instruct patient regarding self-stretches.

Prescription

PRN Number of Visits per Week: _____ Total Number of Visits: _____

Physician's Signature: _____

License #: _____ UPIN: _____