Prescription Referral Form

Beaverton Massage Studio LLC
3800 SW Cedar Hills Blvd STE 207, Beaverton OR 97007
503-754-7949

FROM (physician name):_____
Date:_____
Address:_____
Phone:_____Fax:_____
Email:_____
To: Mallorylawvor.lmt@gmail.com.
Regarding Patient:_____

Treatment Is Medically Necessary.
Please treat the patient for diagnoses listed below, using modalities/ procedures marked below that are within your scope of practice

Modalities/ Procedures:
____97124 Massage Therapy
____97140 Manual Therapy Techniques
____97010 Hot or Cold Packs
____Practitioner's Discretion

Condition Related To:
____Auto Collision Date of Injury____
____Work Injury
____Illness_____
____Other

Diagnosis Codes

__Cervicalgia M54.2

__Lumbar Sprain/Strain M54.5

__Carpal Tunnel G56.00

__Sciatica M54.31, M54.32
__Headache R51, G43.909

Other Diagnosis Codes

Duration and Frequency of Treatment

_____ time(s) per week for _____ weeks OR_____

Treatment Goals

___Decrease Pain

___Decrease Inflammation

___Decrease Muscle Tension/Spasms

___Increase Mobility/Range of Motion

___Other

Other Instructions

Physician's Signature_____ Date_____

NPI#_____