Prescription/Letter of Referral

“The following prescribed treatment is medically necessary”

Date: _____

Patient name: _____

Provider name: _____

Provider phone: _____

Provider address: _____

_____

Referred to: Natalie Condon, LMT at Bear Heart Integrated Bodywork

Any of the following Physicians Current Procedural Terminology, CPT procedures and/or modalities, that are within this therapist’s scope of practice and training, and state and/or Patient’s Insurance Policy regulations, may be used as the therapist deems necessary during any treatment session. Normally four units allowed per visit. One unit = 15 minute segments of time. Conditions or prescriptions may require more units.

Procedures and Modalities

97010 ___ Application of Hot or Cold Packs (as necessary)
97124 ___ Massage Therapy
97140 ___ Manual Therapy Techniques
97112 ___ Neuromuscular Reeducation
97110 ___ Therapeutic Exercises

Provider’s Diagnosis of Patient

S13.8XXA ___ CERVICAL, Includes whiplash Spr/Str
S43.80XA ___ INFRASPINATUS Spr/Str R/L
S43.80XA ___ SUBSCAPULARIS Spr/Str R/L
S63.509A ___ WRIST Spr/Str (Unspecified site) R/L
S23.3XXA ___ THORACIC (DORSAL) Spr/Str
S33.8XXA ___ SACRUM Spr/Str
S73.109A ___ HIP & THIGH (Unspecified site) Spr/Str
S93.409A ___ ANKLE (Unspecified site) Spr/Str R/L
G43.909 ___ MIGRAINES

T14.90 ___ PELVIS (unspecified site) Spr/Str
M54.17 ___ LUMBOSACRAL RADICULITIS R/L
M62.50 ___ MYELOFIBROSIS: Muscles, Ligaments, Fascia
M54.2 ___ CERVICALGIA (Pain in Neck)
S03.4XXA ___ JAW (TMJ & Ligament) Spr/Str R/L
S43.409A ___SHOULDER & ARM (Unspecified site) R/L
S53.409A ___ ELBOW & FOREARM (Unspecified site) R/L
S63.90XA ___ HAND Spr/Str (Unspecified site) R/L
S33.5XXA ___ LUMBAR Spr/Str
S83.90XA ___ KNEE OR LEG Spr/Str R/L
S33.9XXA ___ SACROILIAC REGION R/L
S93.609A___ FOOT (Unspecified site) Spr/Str R/L
G56.00 ___ CARPAL TUNNEL SYNDROME R/L
M62.838 ___SPASM OF MUSCLE_____
M54.30 ___ SCIATICA Spr/Str
M79.7 ___ MYALGIA & MYOSITIS
M54.6 ___ PAIN IN THORACIC SPINE
R.51 ___ HEADACHES

Treatment Sessions Per Week: ____ for ___ Weeks,
OR: Treatment Sessions Per Month: ____ for ____ Months.

Patients to return or call provider, prior to renewal of prescriptions.

Additional Plan of Care Comments:

_____
_____
_____
_____

Provider's Signature:_____
License #:_____