

Patient Name _____

Date _____

Date of Injury/ Diagnosis _____

ID# / DOB _____

A. Diagnosis

(Include ICD-9 codes that specifically address Manual Therapy Treatment)

If treatment is for lymphedema, additional prescriptions, specifically for made-to-order compression garments, will be necessary at the end of Phase I of Complete Decongestive Therapy

Condition is related to:

Auto Accident _____

Illness _____

Work Injury _____

Other: _____

B. Medically necessary treatment: Implement Plan as Prescribed Below

Application (Primary, Secondary, Tertiary etc.)

Head _____

Neck _____

Shoulders _____

Thoracic Spine _____

Abdomen _____

Lumbar Spine _____

Sacrum/Hips/Pelvis _____

Upper extremities _____

Lower extremities _____

Treatment Type

Manual Therapy _____

Massage Therapy _____

Hot/Cold Packs _____

Manual Lymphatic Drainage _____

Multi-Layered Compression Bandages _____

Self-Care/Exercises _____

Compression Garment Measurement _____

Patient Education _____

Other: _____

Frequency & Duration

1 x week for _____ weeks

2 x week for _____ weeks

_____ x week for _____ weeks

1 x month x _____ months

2 x month x _____ months

_____ x month for _____ months

Other: _____

Treatment Goals

Decrease Pain/Inflammation

Decrease Muscle Tension/Spasms

Decrease Compensatory Patterns

Decrease Lymphedema

Increase Mobility/Strength/Endurance

Restore Function/Posture

Patient Self Care Education

Other: _____

Specific Instructions/Precautions: _____

C. Referring Health Care Provider contact information

HCP Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

E-mail _____

NPI _____

Send initial treatment SOAP notes

Send concluding treatment SOAP notes

Send progress report after _____ treatments

Send concluding treatment report

Reports not required at this time

HCP Signature _____

Date _____