Prescription Referral Form

Beaverton Massage Studio LLC
14631 SW Millikan Way STE 11, Beaverton OR 97006
(P) 503-754-7949 (F) 503-662-6115

FROM (physician name):_____
Date:_____
Address:_____
Phone:_____Fax:_____
Email:_____
To: Mallorylawvor@beavertonmassagestudio.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 Collison 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#_____