Massage Therapy Referral / Prescription / Treatment Plan

Please Fax Prescriptions / Treatment plans to Organic Wellness 360-754-4703

From ____ **Date** ________________________

Address

Phone_______________________ Fax_______________________

TO: Organic Wellness Fax**: 360-754-4703**
1210 Sleater Kinney Rd Se **Phone**:360-352-4511
Lacey Wa 98503

Regarding Patient ____

TREATMENT IS MEDICALLY NECESSARY
Please treat the patient for diagnoses indicated below, using the modalities/procedures check-marked below that are within your scope of practice.

1. **Diagnosis Codes**

847.0____ Cervical Sprain / Strain
847.1____ Thoracic Sprain / Strain
846.0____ Lumbosacral Sprain / Strain
846.1____ Sacroiliac Sprain/Strain
846.0____ Lumbosacral Sprain Strain

723.1 ____ Cervicalgia
784.0 ____ Headache
354.0 ____ Carpal Tunnel Syndrome
353.0 _____Thoracic Outlet Syndrome
354.0 _____Carpal Tunnel Syndrome
Other_______________________________
____

2. **Duration and Frequency of Treatment**

_____ **times** per week **for** _____ weeks **OR** #_____ treatments
Or ____

3**. Physician's Signature** ______________________________ **Date** ________________

– –

NPI #_____________________________

Send progress report.
____ After 1st Visit ____ Near end of Rx. Fax report to: _______________________

Notes: