Prescription Form

Please treat my patient, ____________________________________, for the diagnoses indicated below using the modalities or procedures prescribed that are within your scope of practice.

MODALITIES / PROCEDURES

97140 ___ Manual Therapy, Lymphatic Drainage, Myofascial release
97036 ___ Hydrotherapy (Full Immersion Epsom Salt Therapy)
97810 ___ Acupuncture
97124 ___ Massage Therapy
90880 ___ Hypnotherapy

DX CODE

______ Carpal Tunnel Syndrome
______ Cervicalgia
______ Upper Extremities: Brachial Neuritis / Radiculitis
______ Sciatica
______ Lumbosacral / Thoracic Neuritis or Radiculitis
______ Fibromyalgia / Myalgia / Myositis
______ Headache
______ Shoulders-Upper Arms Sprain / Strain
______ Lumbosacral Sprain / Strain
______ Cervical Sprain / Strain
______ Thoracic Sprain / Strain
______ Lumbar Sprain / Strain
______ Sacral Sprain / Strain
______ T.M.J. Sprain / Strain
______ Lymphedema, Lymphangiectasis, Lymphatic obstruction, Lymphatic vessel obliteration
______ Postmastectomy lymphedema syndrome
______ Collision with motor vehicle (driver)
______ Collision with motor vehicle (passenger)

Other pertinent DX codes:

1. ____________________
2. ____________________
3. ____________________
4. ____________________

Additional notes to Therapist ____

Referred to:

A Healing Trail Wellness Center

500 Burlington Rd. Harwinton, CT. 860-485-0405

# of times per week ___________ x # of weeks ______________ = Number of total Visits _________

The above requested treatments are MEDICALLY NECESSARY for this patient.

Physician's Signature____ CT License # ______________

Physician's Name Printed ____ Date _________________

OFFICE STAMP