Prescription Form

Patient Name: _____ Date of Birth: _____

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

MODALITIES / PROCEDURES (CPT Codes):
97140 ___ Manual Therapy, Lymphatic Drainage, Myofascial release
97010 ___ Hot/Cold Packs

DX CODE: PLEASE FILL IN PROPER ICD-10 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
_____ Lymphedema, Lymphangiectasis, Lymphatic obstruction, Lymphatic vessel obliteration
_____ Post-mastectomy lymphedema syndrome
_____ Collision with motor vehicle (driver)
_____ Collision with motor vehicle (passenger)

Other:

1. _____
2. _____
3. _____
4. _____

Additional notes to Therapist _____

Referred to:

The Holistic Connection

1 Grist Mill Rd Suite 2B – Simsbury, CT 06070 860.264.5625 www.theholisticconnection.com

#_____ x of times per week _____# 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