

PRESCRIPTION / LETTER OF REFERRAL

“THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY”

DATE: ____/____/____

PATIENT: _____

PHYSICIAN: _____

ADDRESS: _____

PHONE: _____

FAX: _____

REFERRED TO: **Hawaiian Experience Spa, 10855 N. 116th St, Scottsdale, AZ 85259 | 480-661-2991**

PROCEDURES and MODALITIES AUTHORIZED (as needed):

- Massage Therapy, CPT Code 97124
- Manual Therapy Techniques, CPT Code 97140

PHYSICIAN’S DIAGNOSIS OF PATIENT

- | | |
|--|--|
| 346. <input type="checkbox"/> MIGRAINES | 847.2 <input type="checkbox"/> LUMBAR Sprain/Strain |
| 784.0 <input type="checkbox"/> HEADACHES | 848.9 <input type="checkbox"/> PELVIS (unspecified site) Sprain/Strain |
| 847.0 <input type="checkbox"/> CERVICAL, Inc. Whiplash Injury, Sprain/Strain | 843.9 <input type="checkbox"/> HIP & THIGH (unspecified site) |
| 848.1 <input type="checkbox"/> JAW (TMJ & Ligament) Sprain/Strain R___ L___ | 846.9 <input type="checkbox"/> SACROILIAC REG (unspecified site) Sprain/Strain |
| 723.1 <input type="checkbox"/> CERVICALGIA (pain in the neck) | 847.3 <input type="checkbox"/> SACRUM Sprain/Strain |
| 840.3 <input type="checkbox"/> INFRASPINATUS Sprain/Strain R___ L___ | 724.4 <input type="checkbox"/> LUMBOSACRAL RADICULITIS R___ L___ |
| 840.5 <input type="checkbox"/> SUBSCAPULARIS Sprain/Strain R___ L___ | 724.3 <input type="checkbox"/> SCIATICA (neuralgia, neuritis) R___ L___ |
| 840.6 <input type="checkbox"/> SUPRASPINATUS Sprain/Strain R___ L___ | 844.9 <input type="checkbox"/> KNEE OR LEG Sprain/Strain R___ L___ |
| 840.9 <input type="checkbox"/> SHOULDER & ARM (unspecified site) R___ L___ | 845.00 <input type="checkbox"/> ANKLE (unspecified site) Sprain/Strain R___ L___ |
| 841.9 <input type="checkbox"/> ELBOW & FOREARM (unspecified site) R___ L___ | 845.10 <input type="checkbox"/> FOOT (unspecified site) Sprain/Strain R___ L___ |
| 842.00 <input type="checkbox"/> WRIST Sprain/Strain (unspecified site) R___ L___ | 728.2 <input type="checkbox"/> MYOFIBROSIS; muscles, ligament, fascia |
| 354.0 <input type="checkbox"/> CARPAL TUNNEL SYNDROME R___ L___ | 728.85 <input type="checkbox"/> SPASM OF MUSCLE _____ |
| 842.10 <input type="checkbox"/> HAND Sprain/Strain (unspecified site) R___ L___ | 729.1 <input type="checkbox"/> MYALGIA & MYOSITIS (fibromyositis) |
| 724.1 <input type="checkbox"/> PAIN IN THORACIC SPINE | 728.9 <input type="checkbox"/> Unspecified Disorder of Muscle, Ligament, Fascia |
| 847.1 <input type="checkbox"/> THORACIC (DORSAL) Sprain/Strain | Other <input type="checkbox"/> _____ |

Times Per Week: ____ for ____ Weeks, OR Times Per Month: ____ for ____ Months, OR Total Visits This Script ____

Patient to return or call prior to renewal of prescription

PLAN OF CARE/COMMENTS:

PHYSICIAN’S SIGNATURE: _____ NPI#: _____