# Eagle River Therapeutic Massage

## Massage Referral / Prescription / Treatment Plan

Please Fax to (907) 622-4001

To: Eagle River Therapeutic Massage LLC Fax: 907- 622 - 4001 Phone: 907-351-7191

NPI 1689969966 Mailing Address: 24712 Teal Loop, Chugiak, AK 99567
Office location: 10421 VFW Rd, Eagle River, AK 99577

**Regarding Patient** ___________________________________________

**INJURY INFORMATION**

Diagnosis Codes: DOI: ________________

354.0____ Carpal Tunnel Syndrome

723.1____ Cervicalgia
723.4____ Brachial Neuritis / Radiculitis (Upper Extremities)
724.3____ Sciatica
724.4____ Lumbosacral / Thoracic Neuritis Or Radiculitis (Lower Extremities)
729.1____ Fibromyalgia / Myalgia / Myositis
784.0____ Headache
840.9____ Shoulders-Upper Arms Sprain/Strain
846.0____ Lumbosacral Sprain / Strain
847.0____ Cervical Sprain / Strain
847.1____ Thoracic Sprain / Strain
847.2____ Lumbar Sprain / Strain
847.3____ Sacral Sprain / Strain
847.4____ Coccyx Sprain / Strain
848.1____ T.M.J. Sprain / Strain

Condition is related to:
_____ Auto Accident
_____ Work Injury
_____ Illness
_____ Other ______________

Other Dx Codes
1. ____________
2. ____________
3. ____________
4. ____________

**TREATMENT INFORMATION**

Modalities/Procedures:

97124 _____ Massage Therapy
97140 _____ Manual Therapy Techniques
97010 _____ Hot or Cold Packs

Duration and Frequency of Treatment:

_____ times per week for _____ weeks
Or ______________________________

Treatment Goals

_____ Decrease Pain
_____ Decrease Inflammation
_____ Decrease Muscle Tension / Spasms
_____ Increase Mobility / Range of Motion
_____ Other ___________________________

**Reporting** Please update doctor with client's progress ___ Yes ___ No
_____ Send Report after Initial Visit
_____ Send Report at End of Rx
_____ Other ______________________________________

Reporting Method
_____ Fax
_____ Mail

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

**PHYSICIAN INFORMATION:**

Name of referring Dr. ________________________________ Provider #________________

Address: ________________________________ City: ________________

State: ______________ Zip: ______________ Phone #: ________________ Fax #: ________________

Physicians Signature: ________________________________ Date: ______________