

# PHYSICIAN'S PRESCRIPTION

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

From (Physician): \_\_\_\_\_

Physician's Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ FAX \_\_\_\_\_

## MEDICALLY NECESSARY TREATMENT

- |   |   |
|---|---|
| <input type="checkbox"/> Manual Therapy/ Soft Tissue Manipulation | <input type="checkbox"/> Therapeutic Activities |
| <input type="checkbox"/> Neuromuscular Re-Education               | (flexibility & range of motion)                 |
| <input type="checkbox"/> Myofascial Release / Soft Tissue         | <input type="checkbox"/> Trigger Point Therapy  |
| <input type="checkbox"/> Manual Traction                          | <input type="checkbox"/> Cold Packs             |
| <input type="checkbox"/> Ultrasound                               | <input type="checkbox"/> Heat Packs             |
| <input type="checkbox"/> Structural Integration                   | <input type="checkbox"/> Other _____            |

Please check one:

Treatment is for     Pain     Rehabilitation     Both

### TREATMENT FOR THE FOLLOWING AREAS: (DX CODES)

- |                                 |                           |                            |                            |                               |
|---------------------------------|---------------------------|----------------------------|----------------------------|-------------------------------|
| <input type="checkbox"/> 524.6  | TMJ Syndrome              |                            |                            |                               |
| <input type="checkbox"/> 784.0  | Headaches                 |                            |                            |                               |
| <input type="checkbox"/> 953.8  | Flexion/Extension Injury  |                            |                            |                               |
| <input type="checkbox"/> 847.0  | Cervical Strain/Sprain    |                            |                            |                               |
| <input type="checkbox"/> 840.0  | Shoulder Strain /Sprain   | <input type="checkbox"/> R | <input type="checkbox"/> L | <input type="checkbox"/> Both |
| <input type="checkbox"/> 723.4  | Brachial/Radiculitis      | <input type="checkbox"/> R | <input type="checkbox"/> L | <input type="checkbox"/> Both |
| <input type="checkbox"/> 841.0  | Elbow Strain/Sprain       | <input type="checkbox"/> R | <input type="checkbox"/> L | <input type="checkbox"/> Both |
| <input type="checkbox"/> 842.0  | Wrist Strain/Sprain       | <input type="checkbox"/> R | <input type="checkbox"/> L | <input type="checkbox"/> Both |
| <input type="checkbox"/> 847.1  | Thoracic Strain/Sprain    |                            |                            |                               |
| <input type="checkbox"/> 847.2  | Lumbar Strain/Sprain      |                            |                            |                               |
| <input type="checkbox"/> 846.0  | Lumbosacral Strain/Sprain |                            |                            |                               |
| <input type="checkbox"/> 724.3  | Sciatica                  |                            |                            |                               |
| <input type="checkbox"/> 848.5  | Pelvic Strain/Sprains     |                            |                            |                               |
| <input type="checkbox"/> 724.4  | Sacrum Strain/Sprain      |                            |                            |                               |
| <input type="checkbox"/> 728.85 | Myofascial Pain Syndrome  |                            |                            |                               |
| <input type="checkbox"/> _____  | Other _____               |                            |                            |                               |

Number of Weeks: \_\_\_\_\_ times per week \_\_\_\_\_

Physicians Signature \_\_\_\_\_

License Number \_\_\_\_\_

UPIN Number \_\_\_\_\_