



# Massage Therapy Referral / Rx / Treatment Plan

Please fax to J. Vaughn, LMT, at 413-536-0320

FROM: Doctor \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Cell \_\_\_\_\_

To: **J. Vaughn, LMT**  
**755 Grattan St.**  
**Chicopee, MA 01020**

Fax: **413-527-0320**  
Phone: **413-695-9931**  
e-mail: **jvaughn@massagetherapy.com**

Regarding Patient \_\_\_\_\_

### TREATMENT IS MEDICALLY NECESSARY

Please treat the patient for diagnoses indicated below, using the modalities/procedures check-marked below that are within your scope of practice.

#### Modalities/Procedures

97124 \_\_\_\_\_ Massage Therapy  
97140 \_\_\_\_\_ Manual Therapy Techniques  
97010 \_\_\_\_\_ Hot or Cold Packs

#### Condition is related to:

\_\_\_\_\_ Auto Accident \_\_\_\_\_ Other \_\_\_\_\_  
\_\_\_\_\_ Work Injury \_\_\_\_\_  
\_\_\_\_\_ Illness \_\_\_\_\_

#### Diagnosis Codes

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

#### Other Dx Codes

1. \_\_\_\_\_  
2. \_\_\_\_\_  
3. \_\_\_\_\_  
4. \_\_\_\_\_

#### Duration and Frequency of Treatment

\_\_\_\_\_ times per week for \_\_\_\_\_ weeks

OR \_\_\_\_\_ treatments

OR \_\_\_\_\_

#### Treatment Goals

\_\_\_\_\_ Decrease Pain  
\_\_\_\_\_ Decrease Inflammation  
\_\_\_\_\_ Decrease Muscle Tension / Spasms  
\_\_\_\_\_ Increase Mobility / Range of Motion  
\_\_\_\_\_ Other \_\_\_\_\_

#### Other Instructions

<u>Provide</u>	<u>Yes</u>	<u>No</u>
Self-Care Education	_____	_____
Exercise Education	_____	_____
Ergonomic Education	_____	_____

#### Reporting

\_\_\_\_\_ Send Report after Initial Visit  
\_\_\_\_\_ Send Report at End of Rx  
\_\_\_\_\_ Other \_\_\_\_\_

#### Reporting Method

\_\_\_\_\_ Fax  
\_\_\_\_\_ Mail

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

License # \_\_\_\_\_ UPIN # \_\_\_\_\_