

PRESCRIPTION/LETTER OF REFERRAL
"THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY"
DATE: __/__/__

Patient: _____

Physician: _____ Phone: _____

Address: _____

Referred to: Benjamin Eichenauer, LMT, Certified Advanced Rolfer
4031 SE Hawthorne Blvd. • Portland, OR 97214
P: 503-280-5665 • F: 503-280-5665

Any of the following Physicians' *Current Procedural Terminology, CPT™* procedures and/or modalities, that are within this therapists' scope of practice, and training, &/State &/or Patient's Insurance Policy regulations, may be used as therapist deems necessary during any treatment session. Normally four units allowed per visit. A Unit = 15 minute segments of time. Conditions or prescriptions may require more units.

PROCEDURES and MODALITIES

97140 MYOFASCIAL RELEASE

97124 MASSAGE THERAPY

PHYSICIAN'S DIAGNOSIS OF PATIENT

- | | |
|--|--|
| 346.9 <input type="checkbox"/> MIGRAINES | 847.2 <input type="checkbox"/> LUMBAR Spr/Str |
| 784.0 <input type="checkbox"/> HEADACHES | 848.9 <input type="checkbox"/> PELVIS (unspecified site) Spr/Str |
| 847.0 <input type="checkbox"/> CERVICAL, Includes whiplash spr/str | 843.9 <input type="checkbox"/> HIP & THIGH (unspecified site) Spr/Str |
| 848.1 <input type="checkbox"/> JAW (TMJ & Ligament) spr/str R_L_ | 846.9 <input type="checkbox"/> SACROILIAC REGION (unspecified site) Spr/Str |
| 723.1 <input type="checkbox"/> CERVICALGIA (pain in neck) | 847.3 <input type="checkbox"/> SACRUM Spr/Str |
| 840.3 <input type="checkbox"/> INFRASPINATUS Spr/ Str tendon R_L_ | 724.4 <input type="checkbox"/> LUMBOSACRAL RADICULITIS R_L_ |
| 840.5 <input type="checkbox"/> SUBSCAPULARIS Spr/Str R_L_ | 724.3 <input type="checkbox"/> SCIATICA (neuralgia, neuritis) R_L_ |
| 840.6 <input type="checkbox"/> SUPRASPINATUS Spr/Str R_L_ | 844.9 <input type="checkbox"/> KNEE OR LEG Spr/Str R_L_ |
| 840.9 <input type="checkbox"/> SHOULDER & ARM (unspecified site) R_L_ | 845.00 <input type="checkbox"/> ANKLE (unspecified site) Spr/Str R_L_ |
| 841.9 <input type="checkbox"/> ELBOW & FOREAREM (unspecified site) R_L_ | 845.10 <input type="checkbox"/> FOOT (unspecified site) Spr/Str R_L_ |
| 842.00 <input type="checkbox"/> WRIST Spr/Str (unspecified site) R_L_ | 728.2 <input type="checkbox"/> MYOFIBROSIS: muscles, ligament, facia |
| 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: Muscle, ligament, facia |
| 847.1 <input type="checkbox"/> THORACIC (DORSAL) Spr/Str | Other <input type="checkbox"/> _____ |

Total Visits: _____
Patient to return or call, prior to renewal of prescription

PLAN OF CARE/COMMENTS: _____

PHYSICIAN'S SIGNATURE: _____ LICENSE: _____