

PHYSICIAN'S PRESCRIPTION & REFERRAL

For services provided @
Health Enhancement Therapies

Kimberly A. Carlson, CMT

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Specializing in pain relief and injury rehabilitation massage.

Patient Name _____ DATE _____

DOB _____ CASE # _____

DX CODES _____

Diagnoses _____

Frequency & Duration of Treatment _____
(Number of Sessions) (How many weeks, etc.)

Specific Goals _____

Precautions _____

MODALITIES / PROCEDURES

97001 X Initial evaluation
97010 X HOT OR COLD PACKS
97018 _____ PARAFFIN BATH
97026 _____ INFRARED HEAT
97036 _____ HYDROTHERAPY (ATTENDED)
97039 _____ UNLISTED MODALITIES (SPECIFY)
97110 X THERAPEUTIC EXERCISE (R.O.M.)
97112 X NEUROMUSCULAR RE-EDUCATION
97122 _____ MANUAL TRACTION
97124 X MASSAGE THERAPY
97139 _____ UNLISTED PROCEDURES (SPECIFY)
97140 X MANUAL THERAPY TECHNIQUES

Additional Comments:

This prescription is an evaluate and treat order unless specified otherwise above.

I CERTIFY THAT THE ABOVE TREATMENT PLAN IS MEDICALLY NECESSARY AND IS APPROVED.

Physician Signature _____
(this must be signed by Doctor in order for you to receive treatment)

Printed Name _____

Physician NPI # _____ License # _____