Marjorie Brook, LMT

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Please treat my patient, ______________________________________, for the diagnoses indicated below using the modalities or procedures prescribed that are within your scope of practice.

MODALITIES / PROCEDURES

97140 ___ Manual Therapy, Lymphatic Drainage, Myofascial release 97124 ___ Massage Therapy
97010 ___ Hot or Cold Packs

DX CODES

354.0 ___ Carpal Tunnel Syndrome
723.1 ___ Cervicalgia
723.4 ___ Upper Extremities: Brachial Neuritis / Radiculitis
724.3 ___ Sciatica
724.4 ___ Lumbosacral / Thoracic Neuritis or Radiculitis
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
848.1 ___ T.M.J. Sprain / Strain
457.1 ___ Lymphedema, Lymphangiectasis, Lymphatic obstruction, Lymphatic vessel obliteration
457.0 ___ Postmastectomy lymphedema syndrome
E812.0 ___ Collision with motor vehicle (driver)
E812.1 ___ Collision with motor vehicle (passenger)

Other pertinent DX codes:

1. ______________________
2. ______________________
3. ______________________
4. ______________________

Additional notes to Therapist ____

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# of times per week ___________ x # of weeks ______________ = Number of total Visits _________

The above requested treatments are MEDICALLY NECESSARY for this patient.

Physician's Signature________________________NY License #_________________________

Physician's Name Printed____ Date _______

Physician's Phone & Address____