

Marjorie Brook, LMT

47 Deer lane Wantagh, NY 11793

516-409-1240 marjorie@marjoriebrook.com

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

Other pertinent DX codes:

- | | |
|--|----------|
| 354.0 ___ Carpal Tunnel Syndrome | 1. _____ |
| 723.1 ___ Cervicalgia | 2. _____ |
| 723.4 ___ Upper Extremities: Brachial Neuritis / Radiculitis | 3. _____ |
| 724.3 ___ Sciatica | 4. _____ |
| 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) | |

Additional notes to Therapist _____

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 _____