

Massage Therapy Referral / Prescription / Treatment Plan

Referring to Coastal Therapeutic Massage. 400 Gloucester St., Ste 201 Brunswick, GA 31520

Donna Motamedi, LMT Lic# MT011181

Referring Doctor _____

Date _____ Phone _____

Patient Information

Name: _____

DOB: _____ Phone: _____

If this is Workers' Comp/Auto/Personal Injury, please include contact Information, claim number, date of injury/onset:

TREATMENT IS MEDICALLY NECESSARY for above mentioned patient. Please treat the patient for diagnoses indicated below, using the modalities/procedures check-marked below that are within your scope of practice. Modalities/Procedures Condition is related to:

97124 _____ Massage Therapy

97140 _____ Manual Therapy Techniques

97010 _____ Hot or Cold Packs (_____ at therapist's discretion)

_____ Other _____

Diagnosis Codes ICD-10

1 _____ 2 _____ 3 _____ 4 _____

Duration and Frequency of Treatment:

_____ times per week for _____ weeks ; OR _____ treatments

Treatment Goals:

_____ Decrease Pain _____ Decrease Inflammation _____ Decrease Muscle Tension / Spasms

_____ Increase Mobility / Range of Motion _____ Provide Yes No Self-Care Education

Physician's Signature _____ Date _____

License # _____ NPI # _____

Address: _____