**Referral for Therapy**

**From**: Dr:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **To**: Bodies in Balance Massage Therapy

 Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 408 N Kendrick St, Suite 1

 Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Flagstaff AZ 86001

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ph: (928) 853-5765 / fax: (928) 304-7174

 Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ bodiesinbalanceflagstaff@gmail.com

 Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ www.bodiesinbalanceflagstaff.com

 Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Therapy Prescription**

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Treatment is Medically Necessary. Please treat the patient for the diagnosis indicated below, using the procedures that are within your scope of practice, unless otherwise noted.

**DX Code(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Affected Area(s):** \_\_ C-spine \_\_ T-spine \_\_\_ L-spine \_\_ (R L) Ankle/Foot \_\_ (R L) Knee

 \_\_ (R L) Hip \_\_ (R L) Hand \_\_\_ (R L) Shoulder \_\_\_ Head/Face

 \_\_ Abdomen \_\_ Chest \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Rx Objectives:**

\_\_ Evaluate and Treat \_\_ Stress Reduction \_\_ Pain Relief/Management

\_\_ Increase ROM \_\_ Soft Tissue Mobilization \_\_ Joint Mobilization

\_\_ Other:

**Procedures / Modalities:**

\_\_ 97001, 97002 Evaluation, Re-evaluation \_\_ 97140 Manual Therapy Techniques

\_\_ 97124 Massage Therapy \_\_ 97010 Hot or Cold Packs

\_\_ 97112 Neuromuscular Re-education \_\_ 97110 Therapeutic Exercise (R.O.M., Stretch Therapy)

**Frequency**: \_\_\_\_\_\_\_ times per week for \_\_\_\_\_ weeks and re-evaluate at that time.

 \_\_\_\_\_\_\_ per discretion of therapist.

I am currently treating this patient for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My treatment includes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contraindications / Precautions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Attention Patients**: Call 928-853-5765 to schedule an appointment.

Please fax this RX ahead or bring with you.