Prescription Form

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
97036 ___ Other Hydrotherapy (Full Immersion Epsom Salt Therapy) 90880 ___ Hypnotherapy
97810 ___ Acupuncture

DX CODE

_____ Carpal Tunnel Syndrome
_____ Cervicalgia
_____ Upper Extremities: Brachial Neuritis / Radiculitis
_____ Sciatica
_____ Lumbosacral / Thoracic Neuritis or Radiculitis
_____ Fibromyalgia / Myalgia / Myositis
_____ Headache
_____ Shoulders-Upper Arms Sprain / Strain
_____ Lumbosacral Sprain / Strain
_____ Cervical Sprain / Strain
_____ Thoracic Sprain / Strain
_____ Lumbar Sprain / Strain
_____ Sacral Sprain / Strain
_____ T.M.J. Sprain / Strain
_____ Lymphedema, Lymphangiectasis, Lymphatic Obstruction, Lymphatic Vessel Obliteration
_____ Postmastectomy Lymphedema Syndrome
_____ Collision with motor vehicle (driver)
_____ Collision with motor vehicle (passenger)

Other pertinent DX codes:

1. _____
2. _____
3. _____
4. _____

Additional notes to Therapist _____

Referred to:

A Healing Trail Wellness Center

500 Burlington Rd. Harwinton, CT. 860-485-0405

# of times per week _____ x # of weeks _____ = Number of total Visits _____

The above requested treatments are MEDICALLY NECESSARY for this patient and this patient has not been diagnosed or treated for Covid-19 within the last 12 weeks.

Physician's Signature_____ CT License # _____

Physician's Name Printed _____ Date _____

OFFICE STAMP