Suzanna Dupee

BOARD CERTIFIED MASSAGE THERAPIST

ORTHOPEDIC, DEEP TISSUE, & SPORTS MASSAGE

(919)475-9416 • www.zannamassage.com

PRESCRIPTION REFERRAL *for* MASSAGE THERAPY SERVICES

FROM: Doctor _____ Date_____

Address_____

Phone_____ Fax_____

REGARDING PATIENT: _____

Treatment is medically necessary for diagnosis indicated below using the modalities and procedures check-marked below:

Modalities/Procedures

97124 _____ Massage Therapy
97140 _____ Manual Therapy Techniques
97010 _____ Hot or Cold Packs
97110 _____ Therapeutic Exercise (R.O.M)

Condition is related to:

_____ Auto accident
_____ Work injury
_____ Illness
_____ Other Date of Injury _____

Diagnosis Codes

354.0____ Carpal Tunnel Syndrome
723.1____ Cervicalgia
723.4____ Brachial Neuritis / Radiculitis (UEs)
724.3____ Sciatica
724.4____ Lumbosacral / Thoracic Neuritis / Radiculitis (LEs)
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
847.4____ Coccyx Sprain / Strain
848.1____ TMJ Sprain / Strain

Other Dx Codes:

_____
_____
_____

Duration and Frequency of Treatment

_____ times per week for _____ weeks **OR** _____ treatments

OR _____

Physician's Signature_____ **Date** _____

License #_____ **NPI #** _____

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