PRESCRIPTION / LETTER OF REFERRAL

“ THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY ”

DATE: ______/______/________

PATIENT:____CLAIM #:___________________________

PHYSICIAN: ____________________________ADDRESS: ____

PHONE: ___________________________FAX: ______________________EMAIL:_____________________________

REFERRED TO: IT&B, 5030 S Hwy 17-92, Casselberry, FL 32707, *MM #16412* Phone*: 407.332.6842*
E-mail: Info@itandb.com

Any of the following Physicians’ *Current Procedural Terminology*, CPT™ procedures and / or modalities, <u>which are within this therapist’s scope of practice, training, & / or State & / or Patient’s Insurance Policy regulations,</u> may be used as therapist deems necessary during any treatment session. Normally four units are allowed per visit. A Unit = 15 minute segments of time. Conditions or prescription may require more units.

PROCEDURES and MODALITIES

97010 ☐ HOT/COLD PACKS (as necessary)
97112 ☐ NEUROMUSCULAR RE-ED.
97124 ☐ MASSAGE THERAPY
97140 ☐ MYOFACIAL/MANUAL THERAPY
97035 ☐ ULTRASOUND
_____ ☐ OTHER ____________________________
_____ ☐ OTHER ____________________________

PHYSICIAN’S DIAGNOSIS OF PATIENT

346. ☐ MIGRAINES
354.0 ☐ CARPAL TUNNEL SYNDROME R __ L __
723.1 ☐ CERVICALGIA (pain in neck)
724.1 ☐ PAIN IN THORACIC SPINE
724.3 ☐ SCIATICA (neuralgia, neuritis) R __ L __
724.4 ☐ LUMBOSACRAL RADICULITIS R __ L__
728.2 ☐ MYOFIBROSIS; muscles, ligament, fascia
728.85 ☐ SPASM OF MUSCLE___________________
729.1 ☐ MYALGIA, MYOSITIS , FMS (Fibromyositis)
728.9 ☐ Unspecified Disorder Of MM, Ligament, Fascia
784.0 ☐ HEADACHES
840.3 ☐ INFRASPINATUS Sprain / Strain R __ L __
840.5 ☐ SUBSCAPULARIS Spr /Str (mm) R __ L __
840.6 ☐ SUPRASPINATUS Spr/ Str (mm) R __ L __
840.9 ☐ SHOULDER & ARM (unspecified) R __ L __
841.9 ☐ ELBOW & FOREARM (unspec) R __ L __
842.00 ☐ WRIST Spr / Str (unspecified site) R __ L __
842.10 ☐ HAND Spr / Str (unspecified site) R __ L __
846.0 ☐ LUMBOSACRAL Sprain / Strain
847.0 ☐ CERVICAL, Incl. Whiplash Injury Spr / Str
847.1 ☐ THORACIC (DORSAL) Sprain / Strain
843.9 ☐ HIP & THIGH (unspecified site)
844.9 ☐ KNEE OR LEG Sprain/Strain R __ L __
845.00 ☐ ANKLE (unspecified site) Spr/Str R __ L __
845.10 ☐ FOOT (unspecified site) Spr/Str R __ L __
846.9 ☐ SACROILIAC REGION (unspecified) Spr/Str
847.2 ☐ LUMBAR Sprain / Strain
847.3 ☐ SACRUM Sprain / Strain
847.4 ☐ COCCYX Sprain / Strain
848.1 ☐ JAW (TMJ & Ligament) Spr /Str R __ L__
848.9 ☐ PELVIS (unspecified site) Sprain / Strain
Other ☐ ____________________________________

Times Per Week: ______ for ______ Weeks // OR Times Per Month: ______ for _______Months // Or Total Visits This Script _________

Patient to return or call, prior to renewal of prescription

PLAN OF CARE / COMMENTS:

____
____
____
____
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PHYSICIAN'S SIGNATURE: ____LICENSE: ______________________________

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