PHYSICIAN'S PRESCRIPTION / REFERRAL / MEDICAL NECESSITY

FROM DOCTOR:_____DATE:____-____20____

PHONE: ( ) _____-_____ EMAIL: _____

TO THERAPIST: Jennifer Liu, CMTPT, LMT PH: 773-263-3491 EMAIL: jen@triggerpointchicago.com

ADDRESS: Trigger Point Treatment Center of Chicago, LLC
1150 N. State Street, Suite C315, Chicago, IL 60610

REGARDING PATIENT_____, TREATMENT IS MEDICALLY NECESSARY. Please treat the patient for diagnoses indicated below, using the modalities/procedures checkmarked below that are within your scope of practice.

MODALITIES / PROCEDURES

97010____ HOT OR COLD PACKS
97018____ PARAFFIN BATH
97026____ INFRARED HEAT
97112____ NEUROMUSCULAR RE-EDUCATION
97124____ MASSAGE THERAPY
97140_X__MYOFASCIAL RELEASE

DX CODES

729.1 _X_ MYOFASCIAL DYSFUNCTION
729.0 _X_ MUSCLE PAIN
728.85 _X_ MUSCLE SPASM
354.0____ CARPAL TUNNEL SYNDROME
723.1____ NECK PAIN NEC
724.3____ SCIATICA
724.2____ LOW BACK PAIN
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
524.6 ____ TMJ SYNDROME

OTHER DX CODES
1._____
2._____
3._____
4._____

PHYSICIAN'S SIGNATURE_____

LICENSE#_____UPIN#_____

NPI #_____

 # OF VISITS_____ # OF TIMES PER WEEK_____ # OF WEEKS _____

SPECIAL NOTES_____

_____

I WOULD LIKE A COPY OF THIS PATIENT'S NOTES EMAILED TO ME ☐ YES ☐ NO

ADDRESS: _____

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