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# Prescription

Patient Name ________________________________ Date ____________________

Date of Injury ______________________________ ID# / DOB ______________________________

## A. Diagnosis

(Include ICD-9 codes that specifically address Manual Therapy Treatment)

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

Condition is related to

- ☐ Auto Accident
- ☐ Work Injury
- ☐ Illness
- ☐ Other: ______________________________________

_______________________________________________

_______________________________________________

## B. Medically Necessary Treatment: Implement Plan as Prescribed Below

**Application** (Primary & Secondary)

- ☐ Head
- ☐ Neck
- ☐ Chest
- ☐ Shoulders
- ☐ Abdomen
- ☐ Back
- ☐ Lower back/Hips
- ☐ Upper extremities
- ☐ Lower extremities
- ☐ All of the above
- ☐ Other ______________________________

**Frequency & Duration**

- ☐ 1x wk for _____________ wks
- ☐ 2x wk for _____________ wks
- ☐ 3x wk for _____________ wks
- ☐ 2x month for __________ months
- ☐ 1x month for __________ months

**Treatment Type**

- ☐ Manual Therapy
- ☐ Hot/Cold Packs
- ☐ Self-Care/Exercise
- ☐ Other

**Treatment Goals**

- ☐ Decreased Pain
- ☐ Decreased Inflammation
- ☐ Muscle Tension/Spasms
- ☐ Decrease Compensatory Patterns
- ☐ Increase Mobility
- ☐ Increase Strength
- ☐ Restore Function
- ☐ Restore Posture
- ☐ Patient Education
- ☐ All of the above
- ☐ Other ______________________________________

Specific Instructions/Precautions:

_______________________________________________

_______________________________________________

_______________________________________________

## C. Referring Health Care Provider (HCP)

Contact Information

HCP Name ______________________________

Address ______________________________

City ______________________State _____ Zip__________

Phone ______________________________

Fax ______________________________

Email ______________________________

Reporting – I will send an initial report after the first visit and a progress report after every 6 – 8 sessions. Please check how you would like to receive this information:

☐ Fax ☐ Mail ☐ Email

☐ Send Copies of Chart Notes with each report

HCP Signature: ______________________________________ Date ________________________

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