# Valley Massage Therapy

39 Main Street, Suite 34A, Third Floor
Northampton, Massachusetts 01060
(413)687-7878

FROM: Doctor _____ Date _____

Address _____

Phone _____ Fax _____ Cell _____

To: **Theodore M. Schiff**
**39 Main Street, Suite 34A, Third Floor**
**Northampton, Massachusetts 01060**

**Phone (413)687-7878 Fax (413)461-1298**
**Email: tedschiff@valleymassagetherapy.com**

**Regarding Patient** _____

**TREATMENT IS MEDICALLY NECESSARY**
Please treat the patient for diagnoses indicated below, using the modalities/procedures check-marked below that are within your scope of practice.

**Modalities/Procedures**

**99204_____ Initial Evaluation**
**97124_____ Massage Therapy**
**97140_____ Manual Therapy**
**97112_____ Neuromuscular Re-Education**
**97110_____Therapeutic Exercises**
**97010_____ Hot or Cold Packs**

**Condition is related to:**

_____ Auto Accident
_____ Work Injury
_____ Illness
_____ Other _____
_____

Other Dx Codes
1. _____
2. _____
3. _____
4. _____

**Diagnosis Codes**

**G56.00____ Carpal Tunnel Syndrome**
**M54.2 ____ Cervicalgia**
**M54.10____ Brachial Neuritis / Radiculitis (Upper Extremeties)**
**M54.3 ____ Sciatica**
**M54.17____ Radiculopathy, Lumbosacral**
**M60.9 ____ Fibromyalgia**
**R51 ____ Headache**

**S43.409A ____Shoulder-Upper Arm Sprain / Strain**
**S33.8XXA____ Lumbosacral Sprain / Strain**
**S23.3XXA____ Thoracic Sprain / Strain**
**S13.4XXA____ Cervical Sprain / Strain**
**S03.40XA ____ T.M.J. Sprain / Strain**

**Duration and Frequency of Treatment**

_____ **times** per week **for** _____ weeks

**OR** _____ treatments

**OR** _____ _____

**Treatment Goals**

_____ Decrease Pain
_____ Decrease Inflammation
_____ Decrease Muscle Tension / Spasms
_____ Increase Mobility / Range of Motion
_____ Other _____

**Other Instructions**

| **Provide** | **Yes** | **No** |
|---|---|---|
| Self-Care Education | _____ | _____ |
| Exercise Education | _____ | _____ |
| Ergonomic Education | _____ | _____ |

**Reporting**

_____ Send Report after Initial Visit
_____ Send Report at End of Rx
_____ Other _____

**Reporting Method**

**Physician's Signature** _____ **Date** _____

**License #** _____ **UPIN #** _____