BODIES IN BALANCE
ORTHOPEDIC MASSAGE & STRETCH THERAPY

Relief, Restoration & Healing for
Soft Tissue Pain, Repetitive Strain & Restricted Motion

PRESCRIPTION/REFERRAL FOR TREATMENT

**THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY*

PATIENT: _____ **DATE:** _____

TREATMENT AUTHORIZED:

_____ Evaluate & Treat
_____ Manual Therapy / Soft Tissue Mobilization / Massage
_____ Fascial Stretch / ROM / Flexibility
_____ Corrective Exercise Instruction (Home Program)

DIAGNOSIS: (Please indicate all that apply)

728.85	Muscle Spasm	840.0	Shoulder/Upper Arm Spr/Str.	R or L
729.1	Myositis/Myalgia	726.0	Adhesive Capsulitis Shoulder	R or L
723.1	Cervical/Neck Pain	353.0	Thoracic Outlet Syndrome	R or L
724.1	Thoracic Pain	841.9	Elbow/Forearm Spr/Str.	R or L
724.2	Lumbago/Low Back Pain	842.0	Wrist Sprain/Strain	R or L
724.3	Sciatica	354.0	Carpal Tunnel Syndrome	R or L
847.0	Cervical Sprain/Strain	843.9	Hip/Thigh Sprain/Strain	R or L
847.1	Thoracic Sprain/Strain	844.0	Knee/Lower Leg Spr/Str.	R or L
847.2	Lumbar Sprain/Strain	726.71	Achilles Tendonitis	R or L
846.0	LumboSacral Sprain/Strain	728.71	Plantar Facsciitis	R or L
846.1	Sacroiliac Sprain/Strain	709.2	Scar/Fibrosis	
784.0	Headaches	OTHER: _____		

FREQUENCY/DURATION OF TREATMENT:

_____ x per week _____ weeks **OR** Total # of Visits _____

SPECIAL INSTRUCTIONS: _____
_____
_____

PHYSICIAN SIGNATURE: _____ **NPI #:** _____

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