

Provider Name _____

PRESCRIPTION

Patient Name _____ Date _____

Date of Injury _____ Insurance ID# _____

A. Diagnosis

(Include ICD-10 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 (Direct & Indirect)

- Head _____
- Neck _____
- Chest _____
- Shoulders _____
- Abdomen _____
- Back _____
- Lowback/Hips _____
- Upper extremities _____
- Lower extremities _____
- All of the above _____
- Other: _____

Treatment Type

- Manual Therapy _____
- Hydrotherapy _____
- Self-Care Education _____
- Other _____

Treatment Goals

- Decrease Pain
- Decrease Inflammation
- Decrease Muscle Tension/Spasms
- Decrease Compensatory Patterns
- Increase Mobility
- Increase Strength
- Restore Function
- Restore Posture
- Maintain Associated Structures
- All of the Above
- Other _____

Duration & Frequency

- 1 x wk for _____ wks
- 2 x wk for _____ wks
- 3 x wk for _____ wks
- 2 x month for _____ months
- 1 x month for _____ months

Specific Instructions:

C. Referring Health Care Provider (HCP)

Contact Information

HCP Name _____
 Provider No. _____
 Address _____
 City _____ State ____ Zip _____
 Phone _____
 Fax _____

Reporting

- Send Report After Initial Visit
- Send Report at End of Prescription
- Send Copies of Chart Notes at End of Prescription
- Fax Information
- Mail Information
- Email Information

HCP Signature: _____ Date _____

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