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Referral Form for Massage

Name of Patient Referral: _____

Check all that apply

PROCEDURES

Hot and Cold Pack-907010	Massage Therapy 97124	Neuromuscular Therapy 97112	Manual Therapy 97140
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MODALITIES

Swedish Massage	Deep Tissue	Range of Motion	Stretching
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CONDITIONS

CERVICAL

M53.0-Cervicocranial Syndrome
M54.2-Cervicalgia
M43.6-Torticollis
S13.4xxA-Cervical Ligament Sprain

SACRUM/COCCYX

M53.3- Sacroiliac Pain
M33.8xxA- Sacrum/Coccyx Ligament Sprain

STRESS

M79.7 Fibromyalgia
R51-Headache
G43.909 Migraine NOS

THORACIC

M54.6-Pain in Thoracic Spine
S23.3xxA-Thoracic Ligament Sprain
R07.81- Rib Pain
S23.41xA- Rib Sprain

JOINT PAIN

M25.51-Shoulder Pain, RT
M25.512-Shoulder Pain, LT
M25.521-Elbow Pain, RT
M25.522- Elbow Pain, LT
M25.531- Wrist Pain, RT
M25.32- Wrist Pain, LT
M25.551- Hip Pain, RT
M25.552- Hip Pain, LT
M25.61-Knee Pain, RT
M25.62- Knee Pain, LT

OTHER

M77.12-Lateral Epicondylitis, LT
G56.01-Carpal Tunnel Syndrome, RT
G56.02-Carpal Tunnel Syndrome, LT
M62.830-Muscle Spasm of Back
M62.838-Muscle Spasm of Calf

LUMBAR

M54.5- Lumbago
M54.41- Lumbago with RT Sciatica
M54.42- Lumbago with LT Sciatica
S33.5xxA-Lumbar Ligament Sprain
R10.2- Pelvis Pain

JAW

R68.84-Jaw Pain
M26.61 Adhesion of Temporomandibular Joint
M26.62-Pain in Temporomandibular Joint
S03.4xxA- Jaw Sprain

OTHER ICD-10 DIAGNOSTIC CODES

FREQUENCY & DURATION

PLEASE WRITE SCRIPT FOR NO MORE THAN 3 MONTH INCREMENTS

Starting from Initial Visit: _____ per week for _____ weeks _____ month for _____ months

Total visits for script: _____ Duration of Script: _____

Name of Referring Medical Practice: _____

Name of Referring Doctor & NPI#: _____

Address: _____

Office Phone & Fax #: _____

Physician Signature: _____ Date: ____/____/____