nirvana massage therapy

1 Sanctuary Boulevard, Suite 306
Mandeville, LA 70471
P 985-273-0730
F 985-875-9000
E contactnirvanamt@gmail.com
www.nirvanabalance.com

Massage Therapy Prescription Referral/Treatment Plan

Referring Practitioner Information

Date:_____ Referring Practitioner:_____

❍ MD ❍ DPM ❍ DO ❍ DC ❍ PT ❍ ND/NMD ❍ LPN

Address:_____ City, State, Zip:_____

Phone:_____ Fax:_____ Email:_____

Patient/Client Information

Name:_____ Date of Birth:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Purpose of Referral

Condition is related to: ❍Auto Accident ❍Work Injury ❍Sports Injury ❍Illness ❍Other:_____

Date of Injury/Accident:_____

Diagnosis Code/Description(if not listed below):_____

353.0 ❍ Thoracic Outlet Syndrome
346.0 ❍ Migraines
354.0 ❍ Carpal Tunnel Syndrome
457.0 ❍ Post-Mastectomy Lymphedema
457.1 ❍ Lymphedema, Lipidema
715.9 ❍ Osteoarthritis
716.9 ❍ Arthritis NOS
719.41 ❍ Shoulder Pain
719.42 ❍ Elbow Pain
719.43 ❍ Wrist Pain
719.45 ❍ Hip Pain
719.46 ❍ Knee Pain
719.48 ❍ Joint pain-multiple areas
723.1 ❍ Cervicalgia
723.4 ❍ Brachial Neuritis/Radiculitis (Upper Extremities)
723.9 ❍ Neck-Musculoskeletal Disorders
724.3 ❍ Sciatica
724.4 ❍ Lumbosacral/Thoracic Neuritis/Radiculitis (Lower Ext)
724.5 ❍ Back Pain
724.6 ❍ Back Strain Sacroilliac
728.85 ❍ Muscle Spasm
729.1 ❍ Fibromyalgia/Myalgia
729.5 ❍ Pain in Limb (Arm/Leg)
736.81 ❍ Leg – Acquired Unequal Length
780.7 ❍ Fatigue
784.0 ❍ Headache
839.0 ❍ Cervical Subluxation
840.4 ❍ Rotator Cuff Sprain/Strain
840.9 ❍ Shoulder/Upper Arms Sprain/Strain
842.0 ❍ Wrist Sprain/Strain
845.0 ❍ Ankle/Foot Sprain/Strain
846.0 ❍ Lumbosacral Sprain/Strain
846.1 ❍ Sacroilliac Sprain/Strain
847.0 ❍ Cervical Sprain/Strain
847.1 ❍ Thoracic Sprain/Strain
847.2 ❍ Lumbar Sprain/Strain
847.3 ❍ Sacral Sprain/Strain
847.4 ❍ Coccyx Sprain/Strain
848.1 ❍ TMJ Sprain/Strain
848.9 ❍ Sprain/Strain NOS

Procedures/Modalities

97019 ❍ Hot/Cold Packs
97124 ❍ Massage Therapy
97140 ❍ Manual Therapy: Lymphatic Massage, Myofascial Release
00000 ❍ Therapist Discretion/Other:_____

Duration and Frequency of Therapy

___therapy sessions per week for ___ weeks ___therapy sessions per month for ___ months ___therapy sessions

Start Date:_____ End Date:_____ Other:_____

Treatment Goals

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

Treatment Report

❍No report requested ❍After first session ❍At completion of therapy *Note: Reports sent via email unless otherwise requested*

Statement of Medical Necessity

Therapeutic Massage is medically necessary for the patient listed on this form. Please treat this patient for the specified diagnosis following the duration and frequency prescribed, using the procedures and modalities indicated, and within the guidelines of the scope of practice for Licensed Massage Therapists within the State of Louisiana.

Referring Provider Signature:_____ Date:_____ NPI#:_____

If you would like for us to contact your patient to schedule, please fax or email this form with the patient's complete contact information.
Thank you for your referrals!