SPORTS SOLUTIONS
MASSAGE & WELLNESS

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Massage Therapy Referral Form

Patient Name: _____ DOB: _____

Referring Provider Name:_____

Provider NPI:_____ Facility:_____

Phone:_____ Address:_____ Fax:_____

Modalities/Procedures

97124 _____ Massage Therapy
97140 _____Manual Therapy Techniques
97010 _____Hot or Cold Packs

Condition is Related to:

____ Auto Accident Date of Injury _____
____Work Injury
____Illness
____ Other:_____

Diagnosis Codes

656.02 ____ Carpal Tunnel Syndrome
M54.2 ____ Cervicalgia
M54.12 ____ Brachial Neuritis / Radiculitis (Upper Extremities)
M54.30 ____ Sciatica
M54.15 ____ Lumbosacral / Thoracic Neuritis Or Radiculitis (Lower Extremities)
M79.18 ____ Fibromyalgia / Myalgia / Myositis
R51.9 ____ Headache
S43.409A ____ Shoulder- Upper Arms Sprains/ Strains
S33.BXXA ____ Lumbosacral Sprain / Strain
S16.1 ____ Cervical Sprain / Strain
S23.3XXA ____ Thoracic Sprain/ Strain
S33.5XXA ____ Lumbar Sprain / Strain
S33.8XXA ____ Sacral Sprain / Strain
S33.8XXA ____ Coccyx Sprain / Strain
S03.40XA ____ T.M.J. Sprain / Strain

Other: _____

Duration and Frequency of Treatment

____ times per week for ____ weeks OR ____ treatments

Treatment Goals

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

I certify that the massage therapy services above are medically necessary and approved by me.

Providers Signature:_____ Signed Date:_____