Vital Fitness Holistic Center

Prescription/Letter of Referral

"THE FOLLOWING PRESCRIBED IS MEDICALLY NECESSARY"

Date_____

PATIENT:_____

PHYSICIAN:_____ADDRESS_____

PHONE:_____EMAIL_____

REFERRED TO Vital Fitness Holistic Center THERAPIST Michelle S Krause LMT PHONE 240-903-0980 NPI1548744352

Any of the following Physicians' Current Procedual Terminology, CPT procedures and/or modalities, which are within this therapists' scope of practice and training and/or State Licensing and/or Patient's Insurance Policy regulations, my be used as therapist deems necessary during any treatment session. Normally, 4 procedure units are allowed per visit and 2 modalities. A Unit=15 minute segments of time. Conditions or prescription may require more units.

97140__Manual Therapy Techniques
97112__Neuromuscular Re-Education
97250__Myofascial Release
97124__Massage
97110__Therapeutic Exercise
97026__Infrared
99070__Educational Supplies
97139__Unlisted Procedure (listed by report)
97530__Therapeutic Activities
97039__Unlisted Modality (listed by report)

Procedures and Modalities
Physician's Diagnosis of Patient

ICD-10	Description		ICD-10	Description	
_____	Migraine		_____	Lumbar Sprain/Strain	
_____	Headaches		_____	Pelvis (unspecific site pain/strain)	
_____	Cervical, Inc. Whiplash Injury Sprain/Strain		_____	Hip & Thigh (unspecified site)	
_____	Jaw TMJ (Ligament Sprain/Strain)	R L	_____	Sacroiliac Region (unspecified site)	
_____	Cervicalgia (pain in neck)	R L	_____	Sacrum (Sprain/Strain)	
_____	Infraspinatus (Sprain/Strain)	R L	_____	Lumbosacral Radiculitis	R L
_____	Supraspinatius (Sprain/Strain)	R L	_____	Sciatica (neuralgia, neuritis)	R L
_____	Shoulder & Arm (unspecified site)	R L	_____	Knee or Leg (Sprain/Strain)	R L
_____	Elbow & Forearm (unspecified site)	R L	_____	Ankle (unspecified site-Sprain/Strain)	R L
_____	Wrist (Sprain/Strain-unspecified site)	R L	_____	Foot (unspecified site-Sprain/Strain)	R L
_____	Carpal Tunnel Syndrome		_____	Myofibrosis (muscles, ligament, fascia)	
_____	Hand (Sprain/Strain-unspecified site)	R L	_____	Spasm of Muscle_____	
_____	Pain in Thoracic Spine		_____	Myalgia & Myositis (Fibromyositis)	
_____	Thoracic (Dorsal) (Sprain/Strain)		_____	Unspecified Muscle Disorder, Ligament, Fascia	
_____	Other_____		_____	Other_____	

Times Per Week:_____for____Weeks, OR Times Per Month:____for____Months, or Total Visits This Script_____

Patient to return or call prior to renewal of prescription

Plan of Care/Comments:

Physician's Signature_____ NPI_____