



MASSAGE THERAPY &
WELLNESS CENTER

1375 Regents Blvd.
Suite 202
Fircrest, WA 98466
P: (253) 878-0174

HEALTH CARE PROVIDER PRESCRIPTION / REFERRAL

Date: _____

Referring HCP: _____

Phone: _____

Fax: _____

Massage Therapist:

- Leanne Kuhlman, LMT
- _____, LMT

sprinklakemyotherapy@gmail.com

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Regarding Patient: _____

Treatment is medically necessary. Please treat the patient for diagnosis indicated below, using the modalities/procedure(s) check marked below that are within your scope of practice.

CPT codes:

- 97010: Application of a modality to one or more areas; hot or cold packs
- 97124: Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage, and/or tapotement (stroking, compression, percussion)

ICD-10 Diagnosis Code(s): Descriptor:

_____	_____
_____	_____
_____	_____
_____	_____

Number of visits: _____ To be completed within: _____

Reporting: Massage Therapist will send a Status Report following the last session in the current referral cycle. Please indicate how Referring HCP would like to receive this information:

Fax ___ Mail ___ Email ___ Send copies of chart notes with report ___

Signed: _____

Printed: _____