Medical Massage Therapy Prescription / Referral Form

Anchorage Massage Therapies, LLC

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From: MD, NP _____ Date _____

Address _____Phone_____

Fax_____Email _____

TREATMENT IS MEDICALLY NECESSARY.

___ M79.89: Other specified soft tissue disorders
- Lymphedema consult/treatment

___ E197.2: Post mastectomy lymphedema syndrome
- Elephantiasis due to mastectomy
- Obliteration of lymphatic vessels

___189.8: Other specified non infective disorders of lymphatic vessels and nodes
- Axillary web syndrome

___G54.0: Brachial plexus disorders
- Thoracic Outlet syndrome

___G56.00: Carpal tunnel syndrome, unspecified upper limb

___G900: Peripheral neuropathy

___R68.84: Jaw pain
___M54.2: Cervicalgia
___M54.6: Pain in thoracic spine
___R07.82: Intercostal pain
___M54.5: Lumbago
___M54.30: Sciatica

Addition medical prescription: _____

Duration and frequency:

____ visits per ____ Or _____

Physician's Signature _____**Date** _____