Provider Name : P. Leilani Berry, LMP 206-248-2001 Fax 206-431-5428 **PRESCRIPTION**

Patient Name _____ Date _____

Date of Injury _____ Insurance ID# _____

A. Diagnosis

(Include ICD-10 codes that specifically address Manual Therapy Treatment)

_____

_____

_____

_____

Condition is related to

☐ Auto Accident
☐ Work Injury
☐ Illness
☐ Other: _____

B. Medically Necessary Treatment: Implement Plan as Prescribed Below

Application (Direct & Indirect)

☐ Head _____
☐ Neck _____
☐ Chest _____
☐ Shoulders _____
☐ Abdomen _____
☐ Back _____
☐ Lowback/Hips _____
☐ Upper extremities _____
☐ Lower extremities _____
☐ All of the above _____
☐ Other: _____

Duration & Frequency

☐ 1× wk for _____ wks
☐ 2× wk for _____ wks
☐ 3× wk for _____ wks
☐ 2× month for _____ months
☐ 1× month for _____ months

Treatment Type

☐ Manual Therapy _____
☐ Hydrotherapy _____
☐ Self-Care Education _____
☐ Other _____

Treatment Goals

☐ Decrease Pain
☐ Decrease Inflammation
☐ Decrease Muscle Tension/Spasms
☐ Decrease Compensatory Patterns
☐ Increase Mobility
☐ Increase Strength
☐ Restore Function
☐ Restore Posture
☐ Maintain Associated Structures
☐ All of the Above
☐ Other _____

Specific Instructions:

_____

_____

_____

_____

C. Referring Health Care Provider (HCP)

Contact Information

HCP Name _____
Provider No. _____
Address _____
City _____ State ____ Zip _____
Phone _____
Fax _____

Reporting

☐ Send Report After Initial Visit
☐ Send Report at End of Prescription
☐ Send Copies of Chart Notes at End of Prescription
☐ Fax Information
☐ Mail Information
☐ Email Information

HCP Signature: _____ Date _____