Mark Wallace, Licensed Massage Practitioner (206) 396-8452
Washington State Department of Health: Massage Practitioner License # MA 60197801
***** PLEASE MAKE CHECKS PAYABLE TO KMW, LMP *****

Manual Therapist

PRESCRIPTION

Patient Name ______________________ Date __________

Date of Injury ______________________ ID#/DOB ______________________

A. Diagnosis

(Include ICD-9 codes that specifically address Manual Therapy Treatment)

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Condition is related to

- ☐ Auto Accident
- ☐ Work Injury
- ☐ Illness
- ☐ Other: ______________________

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B. Medically Necessary Treatment: Implement Plan as Prescribed Below

Application (Primary & Secondary)

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

Frequency & Duration

- ☐ 1× wk for ________ wks
- ☐ 2× wk for ________ wks
- ☐ 3× wk for ________ wks
- ☐ 2× month for ________ months
- ☐ 1× month for ________ months

Treatment Type

- ☐ Manual Therapy ______________________
- ☐ Hot/Cold Packs ______________________
- ☐ Self-Care/Exercises ______________________
- ☐ Other ______________________

Treatment Goals

- ☐ Decrease Pain
- ☐ Decrease Inflammation
- ☐ Decrease Muscle Tension/Spasms
- ☐ Decrease Compensatory Patterns
- ☐ Increase Mobility
- ☐ Increase Strength
- ☐ Restore Function
- ☐ Restore Posture
- ☐ Patient Education
- ☐ All of the Above
- ☐ Other ______________________

Specific Instructions/Precautions:

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C. Referring Health Care Provider (HCP)

Contact Information

HCP Name ______________________

Address ______________________

City ______________ State ____ Zip __________

Phone ______________________

Fax ______________________

Email ______________________

Reporting—I will send an initial report after the first visit and a progress report after every 6–8 sessions. Please check how you would like to receive this information:

☐ Fax ☐ Mail ☐ Email

☐ Send Copies of Chart Notes with each report

HCP Signature: ______________________ Date __________

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