Pain to Performance PLLC
Pain to Performance Solutions dba
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PRESCRIPTION / LETTER OF REFERRAL

"THE FOLLOWING PRESCRIBED TREATMENT IS MEDICALLY NECESSARY"

DATE_____/_____/_____

PATIENT: _____

PHYSICIAN:_____ **ADDRESS:** _____

PHONE:_____ **FAX**: _____

REFERRED TO: Alexis Kurtzman LMT (CPT CES RYT) NKT MMP **Phone***: 206-946-2040*

PROCEDURES and MODALITIES

97010	☐	HOT/COLD PACKS (as necessary)	97112	☐	NEUROMUSCULAR
97016	☐	CUPPING THERAPY	97140	☐	NMT RE-EDUCATION
~~97018~~	☐	~~PARAFFIN BATH~~	97124	☐	MASSAGE THERAPY
97026	☐	INFRA-RED Heat Therapy	97140	☐	MANUAL THERAPY TECHNIQUES
97032	☐	ELECTRICAL STIMULATION, attended	97161	☐	Initial Assessment /Evaluation
~~97034~~	☐	~~CONTRAST BATHS~~	97799	☐	Unlisted Physical Medicine Rehab
~~97035~~	☐	~~ULTRASOUND~~		☐	Service or Procedure ie; (By Report) Kinesio Taping, Cupping Therapy, Gua Sha

PHYSICIAN'S DIAGNOSIS OF PATIENT

Please fill in the ICD-10 Codes

ICD-10	☐	Description			ICD-10	☐	Description		
_____	☐	MIGRAINES			_____	☐	LUMBAR Sprain / Strain		
_____	☐	HEADACHES			_____	☐	PELVIS (unspecified site) Sprain / Strain		
_____	☐	CERVICAL, Inc. Whiplash Injury Sprain / Strain			_____	☐	HIP & THIGH (unspecified site)		
_____	☐	JAW TM } & Ligament) Sprain/Strain	R	L	_____	☐	SACROILIAC REGION (unspecified site)		
_____	☐	CERVICALGIA (pain in neck)			_____	☐	SACRUM Sprain / Strain		
_____	☐	INFRASPINATUS Sprain / Strain	R	L	_____	☐	LUMBOSACRAL RADICULITIS	R	L
_____	☐	SUPRASPINATUS Sprain/ Strain (muscle)	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	R	L	_____	☐	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 ☐ _____

Other ☐ _____ Other ☐ _____

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 Prescription Expires _____

PHYSICIAN'S SIGNATURE:_____ **NPI #:** _____

PLAN OF CARE / COMMENTS

_____