

## Physician Referral for Massage Therapy

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Referring Physician: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

Referral To: \_\_\_\_\_ Valid At Practice Location:  
Therapeutic Massage Department  
Butler Chiropractic Health Clinic, PC  
1802 Dearborn Ave., Suite 101,  
Missoula, MT 59801  
Phone (406)-728-5114 Fax (406) 728-8121

Patient name: \_\_\_\_\_ DOB: \_\_\_\_\_

TREATMENT IS MEDICALLY NECESSARY. Please treat the patient for the diagnoses indicated below, using the procedures that are within your scope of practice.

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### Diagnosis Codes:

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| <input type="checkbox"/> 728.85 Spasm of muscle                              | <input type="checkbox"/> 722.51 Degeneration of thoracic intervertebral disc                         |
| <input type="checkbox"/> 784.0 Headache                                      | <input type="checkbox"/> 739.8 Rib Segmental Dysfunction   |
| <input type="checkbox"/> 723.1 Cervicalgia                                   | <input type="checkbox"/> 847.1 Thoracic Sprain/Strain  |
| <input type="checkbox"/> 839.00 Cervical subluxation, unspecified            | <input type="checkbox"/> 724.4 Thoracic or Lumbosacral Radiculitis                                   |
| <input type="checkbox"/> 739.1 Cervical segmental dysfunction                | <input type="checkbox"/> 724.2 Low Back Pain   |
| <input type="checkbox"/> 722.4 Cervical disc degeneration                    | <input type="checkbox"/> 724.3 Sciatica  |
| <input type="checkbox"/> 722.0 Cervical disc displacement without myelopathy | <input type="checkbox"/> 839.20 Lumbar Subluxation   |
| <input type="checkbox"/> 723.4 Cervical radiculitis/brachial neuritis        | <input type="checkbox"/> 739.3 Lumbar & lumbosacral segmental dysfunction                            |
| <input type="checkbox"/> 847.0 Cervical sprain/strain                        | <input type="checkbox"/> 722.10 Herniation/displacement lumbar IVD w/o myelopathy                    |
| <input type="checkbox"/> 724.1 Thoracic spine pain                           | <input type="checkbox"/> 739.4 Sacral, S/I & Sacrococcygeal segmental dysfunction                    |
| <input type="checkbox"/> 839.21 Thoracic subluxation                         | <input type="checkbox"/> 847.2 Lumbar Sprain/Strain  |
| <input type="checkbox"/> 739.2 Thoracic segmental dysfunction                | <input type="checkbox"/> 839.42 Subluxation of sacrum, sacroiliac                                    |
| <input type="checkbox"/> 729.1 Fibromyalgia                                  | <input type="checkbox"/> 738.4 Spondylolisthesis & Spondylolysis (Acquired, degenerative, traumatic) |
| <input type="checkbox"/> 840.9 Shoulder/Upper Arm Sprain/Strain              | <input type="checkbox"/> 724.5 Back pain   |
| <input type="checkbox"/> 726.10 Rotator Cuff Syndrome                        | <input type="checkbox"/> 728.4 Ligament Laxity   |
|  | <input type="checkbox"/> 354.0 Carpal Tunnel Syndrome  |
|  | <input type="checkbox"/> 353.0 Thoracic Outlet Syndrome  |

Other Diagnosis Codes: \_\_\_\_\_

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- Treatment Goals:**  Increase Range of Motion  Increase Circulation  Reduce Edema  
 Decrease Muscle Spasm  Reduce Lymphedema  Promote Soft Tissue Healing  Decrease Pain  
 Assist the individual to achieve maximum functional capacity in performing daily activities  
 Other: \_\_\_\_\_

### Treatment Plan:

Treatment Time:  30 mins  60 mins Frequency:  Weekly  Every 2 weeks  Every 3 weeks  
Duration: \_\_\_ weeks \_\_\_ months Other: \_\_\_\_\_

Precautions or contraindications for this patient:  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature: \_\_\_\_\_ MT License #: 595