Bryant Chiropractic and Massage
Bellevue Pregnancy Massage
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Massage Therapy Referral

Patient Name: _____ Date: _____

Home Address: _____

Home Phone Number:_____ Work Number: _____

Date of Birth:_____ Date of Injury or EDD: _____

Please, check the appropriate diagnosis codes or write up to four ICD-10 codes:

☐ Cervicalgia: **M54.2** 1) **ICD-10:** _____

☐ Pain in Thoracic Spine: **M54.6** 2) **ICD-10:** _____

☐ Pain in Lumbar Spine: **M54.5** 3) **ICD-10:** _____

☐ Myospasm of Low Back: **M62.830** 4) **ICD-10:** _____

☐ Low back pain in pregnancy: **O99.891** ☐ Hip Pain: **M25.559**

☐ Other Muscle Spasm: **M62.838** ☐ Leg Pain: **M79.606**

☐ Arm Pain: **M79.603** ☐ Foot Pain: **M79.673**

Please, Write Frequency Of Treatment: **__1__** Massage a week for total of **_____** visits

Condition To Be Treated Is Related To

☐ Pregnancy ☐ Postpartum ☐ Auto Accident ☐ Injury ☐ Myospasm ☐ Other_____

Additional Notes:_____

_____

Insurance: ☐ Private Insurance ☐ Auto/PIP ☐ 3rd Party/Attorney ☐ L&I

Billing Information: _____

Doctor/Midwife's Name:_____ NPI: _____

Signature:_____

Phone Number:_____ **Fax Number:** _____