Phone & Fax: 907-917-4999

Referral for Evaluation & Treatment

Please attach a copy of the Patient's identification card, insurance card, and most recent chart note.

ALASKA MASSAGE COMPANY

Patient Name: _____

Date of Birth: _____

Intraoral Manual Therapy

____ **M26.00** Unspecified Anomaly of Jaw Size

____ **M26.03** Bilateral TMJ Disorder Unspecified

____ **M26.02** Left TMJ Disorder, Unspecified

____ **M26.01** Right TMJ Disorder Unspecified

____ **M26.09** Unspecified TMJ, Unspecified Side

____ **OTHER:** _____

Manual Lymphatic Drainage

____ **R60** Edema, not elsewhere classified

____ **R60.9** Edema, Unspecified

____ **R60.0** Localized Edema

____ **R60.1** Generalized Edema

____ **E87.70** Fluid Overload, Unspecified

____ **OTHER:** _____

Therapeutic Massage

____ **M54.2** Cervicalgia

____ **M54.6** Thoracic Pain

____ **M54.5** Low Back Pain

____ **G43** Migraine

____ **M54.3** Sciatica

____ **M54.4** Lumbago W/Sciatica

____ **G89.4** Chronic Pain Syndrome

____ **OTHER:** _____

Frequency: 1x/Week ___ 1-2x/Week ___ 2x/Week ___ 2-3x/Week ___ 3x/Week ___

Duration: 4 Weeks___ 6 Weeks___ 8 Weeks___ Other: _____

Send progress report: ____ no report ___ every week ___ every 2 weeks ___ completion of treatment

Referring Provider Details:

Provider Name: _____ Facility: _____

Facility Phone: _____ Facility Fax: _____

Provider Signature: _____ Date: _____