



Prescription and Referral

Advanced Medical Therapeutic Massage Clinic, LLC
Minora Kraftmann, CMT,
NJ Lic. 26BT00398800, NPI 1619235447
Benjamin Kraftmann, MS, CMT,
NJ Lic. 26BT00392700, NPI 1568729465
732 966-2441, email: mkraftmann@yahoo.com

Client Name: _____ Date: _____

Date of Injury: _____ Insurance ID#: _____

Diagnosis (Include Codes)

Condition is related to

- Automobile Accident
- Work Injury
- Other _____

Cautions/Contraindications:

Medically Necessary Treatment: Follow Plan Prescribed

Body areas to be treated

- Head _____
- Neck _____
- Chest _____
- Shoulders _____
- Back _____
- Lowback/Hips _____
- Upper Extremities _____
- Lower Extremities _____
- All of the above _____
- Other _____

Duration and Frequency:

- Daily
- ___ x per wk for ___ wks
- ___ x per month for ___ months

Treatment Type:

- Discretion of massage therapist
- Massage therapy _____
- Self-Care Education _____
- Other _____

Treatment Goals:

- Decrease Pain
- Decrease Muscle Tension/Spasm
- Decrease Compensation patterns
- Increase Mobility
- Increase Function
- Other _____

Reevaluation Date: _____

Additional Instructions:

Referring Healthcare Provider (HCP)

Contact Information

Provider Name _____
 Provider No _____
 Address _____
 Phone _____ Fax _____
 Email _____

Progress Updates

- Send Progress Report after Initial Session
- Send at end of Prescription
- Send copies of Treatment Notes at end of Prescription
- Mail Fax Email

Provider signature: _____ **Date:** _____