Massage Therapy Prescription/Referral

_____ _____

Patient's Name Patient's DOB

Diagnosis with ICD Codes:

1 _____

2 _____

3 _____

Precautions: _____

_____

Frequency:

☐ Daily ☐ 1xW ☐ 2xW ☐ Monthly ☐ As Needed

Number of Visits: _____

Start Date: _____ End Date: _____

Physician Information

_____ _____

Physician Name (please print) Physician NPI

_____

Address (Street, City, State, Zip)

_____ _____

Physician Phone Physician Fax

_____ _____

Physician Signature Date