Referral / Script – Massage Therapy

****If this is a first time referral from your office, please send patient demographics and any pertinent testing related to this referral****

If this is a referral from an auto accident and there is an open and billable claim for auto insurance, this patient may qualify for home visits if leaving is difficult secondary to physical limitations.

Patients Name: _________________________ Date:__________________________

Patient DOB: _____________ Medical Diagnosis/ ICD 10:____________________________

Patient to be seen ____times per week, for _____ min / hour per session for_____ months.

Please check all that apply:

Evaluate and treat for Massage:

- ☐ Myofascial Treatment
- ☐ Cranial Sacral Treatment
- ☐ Effleurage, Petrissage, Friction, and Tapotement Treatment
- ☐ Trigger Point Treatment
- ☐ Deep Tissue Massage
- ☐ Headaches
- ☐ Anxiety / Stress
- ☐ Traumatic Brain Injury
- ☐ Concussion
- ☐ Lymphatic Drainage Treatment
- ☐ Spinal Cord Injury
- ☐ PTSD
- ☐ Balance issues/vertigo
- ☐ Sleep disorder
- ☐ Chronic Pain (neck/back/legs/arms) – all modalities
- ☐ Neuropathy
- ☐ Swelling / ROM _______________
- ☐ Other:_________________________ _______________________________

PHYSICIANS PLEASE LIST medications that may create side effects that interfere with daily functioning, and impairments to mobility and cognition____
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PHYSICIANS PLEASE LIST risk, limitations or contraindications:___________________________________
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Physician Signature_______________________ NPI:____________________________

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