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Provider Referral Form - Massage Therapy

Patient Name:______________________________ DOB:________________

ICD-10:______________________ Patient Phone:________________________

Diagnosis:____

Notes:____

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Treatment Methods

- ❑ Therapeutic Massage
- ❑ Swedish Massage
- ❑ Soft Tissue Mobilization
- ❑ Myofascial Release
- ❑ Cranial-Sacral Therapy
- ❑ Deep Tissue Massage
- ❑ Trigger Point Massage
- ❑ Pregnancy Massage
- ❑ Post-Natal Massage

Treatment Frequency:________ times for_________weeks

Physician Signature:__________________________ Date:______________

Physician Name (Print):________________________ Recheck Date:______________