PHYSICIANS REFERRAL FOR MASSAGE THERAPY

From:_____	Condition is related to ___MVA___work injury
Patient Name:_____	___Other injury ___Stress ___other medical condition
Address:_____	Number of sessions to be done: (frequency and duration)
_____	_____
Insurance Company:_____	Send progress report:
Policy Number:_____	____ every week
Claim Number:_____	____every two weeks
Billing Address:_____	____at the completion of prescribed treatments
_____	____other_____
Date of Injury:_____	Special directions/Comments:_____
Diagnosis:_____	_____
_____	_____
ICD- 9 code (s):_____	_____
_____	

Areas to be worked on: (circle all that apply, add comments)

Cranial: Temporalis, Masseter, Frontalis _____

_____

Cervical: E.S, Levator, Scalenes, SCM, Spenius Cervicus/Capitis, Trapezius, Sub occipitals_____

_____

Thoracic: E.S, Rhomboid, Serratus Anterior, Trapezius, Serratus posterior superior_____

_____

Shoulder: Infraspinatus, Supraspinatus, Subscapularis, Teres , Deltoid, PecMj, PecMn _____

_____

Lumbar: E.S, Quadratus, Iliacus, Psoas_____

_____

Sacral: Gluteus Max, Min, Med, Rotators, IT Band, Quads, Hamstrings, TFL_____

_____

Other:_____

_____

Hydrotherapy: None, Heat, Cold

Location:_____

Physicians Signature_____Date:_____

Physicians Name printed:_____

Address_____

Phone_____

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